CCME

2016 External Quality Review

WELLCARE OF SOUTH CAROLINA

Submitted: January 13, 2017

Prepared on behalf of the
South Carolina Department
of Health and Human Service

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EXECUTIVE SUMMARY

The Balanced Budget Act of 1997 (BBA) requires State Medicaid Agencies that contract with Managed Care Organizations to evaluate their compliance with the state and federal regulations in accordance with 42 Code of Federal Regulations (CFR) 438.358. The purpose of this review was to determine the level of performance demonstrated by WellCare of South Carolina (WellCare) since the 2015 Annual Review. This report contains a description of the process and the results of the 2016 External Quality Review (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) on behalf of the South Carolina Department of Health and Human Services (SCDHHS).

Goals of the review were to:

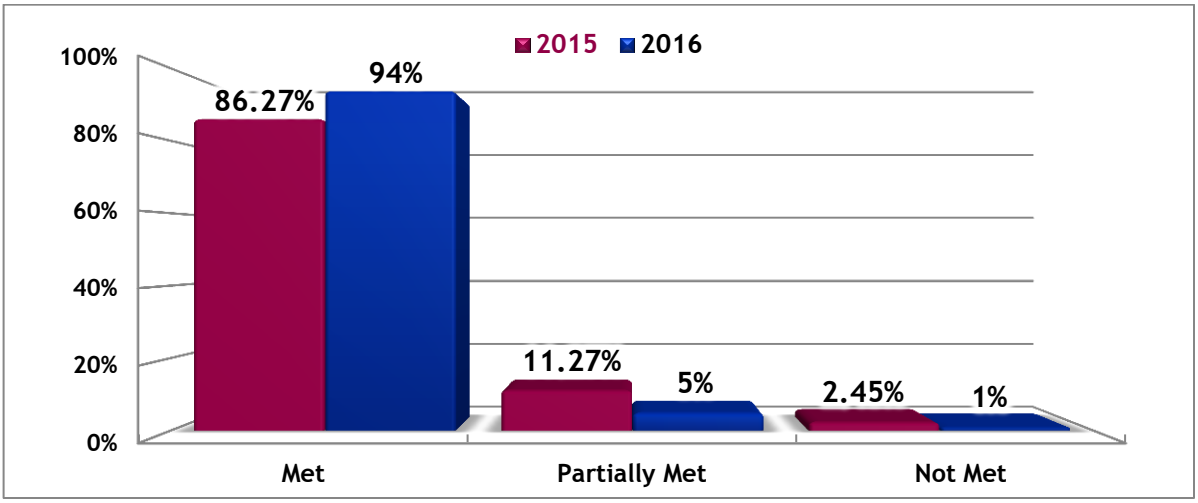
- determine if WellCare was in compliance with service delivery as mandated in the Managed Care Organization (MCO) contract with SCDHHS;
- evaluate the status of deficiencies identified during the 2015 Annual Review and any ongoing corrective action taken to remedy those deficiencies;
- provide feedback for potential areas of further improvement; and
- assure that contracted health care services are actually being delivered and are of good quality.

The process used for the EQR was based on the protocols developed by the Centers for Medicare & Medicaid Services (CMS) for the external quality review of a Medicaid Managed Care Organizations. The review included a desk review of documents, a two-day onsite visit, a telephone access study, compliance review, validation of performance improvement projects, and validation of performance improvement measures.

Overall Findings

The 2016 annual review shows that WellCare has achieved a "Met" score in 94% of the standards reviewed. *Figure 1, Annual EQR Comparative Results*, shows 5% of the standards were scored as "Partially Met," and 1% of the standards scored as "Not Met." *Figure 1* also provides a comparison of WellCare's current review results to the 2015 review results.

Figure 1: Annual EQR Comparative Results



An overview of the findings for each section follows. Details of the review as well as specific strengths, weaknesses, any applicable corrective action items and recommendations can be found further in the narrative of this report.

Administration:

WellCare submitted a comprehensive Compliance Plan and policies and procedures that included South Carolina specific requirements for Program Integrity. WellCare conducts numerous audits and reviews to identify suspected fraud and abuse. IT systems are capable of meeting contract requirements for processing claims, HIPAA compliant transactions, eligibility, and disaster recovery. WellCare had an external security audit performed that identified areas in need of improvement; however, no documentation was submitted that demonstrated how WellCare was addressing or planning to address the issues identified in the audit.

Provider Services:

Onsite discussion confirmed that three network providers have been added to the Credentialing Committee as voting members in the past five months; however, the list of Credentialing Committee members received in the desk materials did not reflect the new committee members. Results of the *Telephonic Provider Access Study*, conducted by CCME, did not show improvement from the previous year review. The successful answer rate was 42% for the current and 46% for the previous year. In addition, WellCare conducted an annual medical record review in 2015 and the results documentation did not explain what criteria was used to determine a failed score, and did not explain what follow up took place for the providers placed on a corrective action plan.

Member Services:

WellCare provides information to new members via the *Member Handbook* and other written materials. For the purposes of this EQR, the 2016 *Draft Member Handbook* was reviewed and will be further referenced in this report as the *Member Handbook*.

The *Member Handbook* is written in appropriate language for ease of understanding. Corresponding information is available on WellCare's website. Benefit grids in the *Member Handbook*, in the *Provider Manual*, and on the WellCare website define covered benefits, benefit limitations, and copayment amounts; however, discrepancies in copayments and benefit limits were noted when comparing the grids from each source.

WellCare uses a certified vendor to conduct annual member satisfaction surveys. Response rates for the most recent member satisfaction surveys were only 18.6% (Child) and 25% (Adult) — lower than for the previous survey. CCME encourages WellCare to work with the vendor to develop and implement strategies to improve survey response rates.

Grievance files were well-documented, with timely resolution and thorough documentation included in the resolution letters. Two files were noted with acknowledgement letters sent outside of the 5 business-day timeframe.

Quality Improvement:

The only Quality Improvement concern found during the review was focused around the performance measures. Comparison from the previous to the current year reveal a strong increase in Use of First Line Psychosocial Care for Children and Adolescent on Antipsychotics with a 48% increase for 6-11 year olds and 48% increase for 12-17 year olds. The most problematic measures were the Immunization Rates with decreases of over 10% on several of the measures. All immunization rates decreased. The HbA1C Poor Control rate increased over 10% and the Adult BMI Assessment rate decreased almost 10%.

Utilization Management:

The Utilization Management program includes detailed policies, procedures and the processes used to make utilization decisions and handle appeals. The file review concluded WellCare makes timely decisions, communicates decisions clearly, and notices include the required elements. WellCare has a High Performing Provider Group program; however, it does not address offering unique authorization arrangements based on improvements in quality. Some discrepancies exist between policies and other documents regarding the Pharmacy Lock-In Program, the appeals process, and interrater reliability testing.

Delegation:

WellCare presented evidence of oversight for the delegated entities that conduct functions for UM, Nurse Line, Pharmacy, Customer Service, Crisis Line, Case Management, Vision, and Credentialing. A few issues were identified with delegated credentialing that are explained in the report, but overall, delegation oversight is thorough. CCME made a few recommendations related to ensuring delegation oversight occurs annually, and ensuring any corrective action plans for the delegated entities are completed according to WellCare policy defined timeframes.

State Mandated Services:

WellCare provides all core benefits required by the *SCDHHS Contract* and encourages members to participate in recommended health screenings and services using a variety of methods, including mailings and telephonic reminders. Care gap reports are disseminated to providers, and providers are able to check for gaps in care via the provider portal available through WellCare's website. Providers are routinely monitored for compliance with EPSDT services, including immunization administration.

Table 1, Scoring Overview, provides an overview of the findings of the current Annual Review as compared to the findings of the 2015 review.

Table 1: Scoring Overview

	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards
Administration						
2015	32	0	0	0	0	32
2016	32	1	0	0	0	33
Provider Services						
2015	64	9	2	0	0	75
2016	70	4	1	0	0	75
Member Services						
2015	33	4	0	0	0	37
2016	35	2	0	0	0	37
Quality Improvement						
2015	13	2	0	0	0	15
2016	15	0	0	0	0	15

Utilization						
2015	31	6	1	0	0	38
2016	35	3	0	0	0	38
Delegation						
2015	0	2	0	0	0	2
2016	1	1	0	0	0	2
State Mandated Services						
2015	3	0	1	0	0	4
2016	4	0	0	0	0	4

METHODOLOGY

The process used by CCME for the EQR activities was based on protocols developed by the Centers for Medicare & Medicaid Services (CMS) for the external quality review of a Medicaid MCO/PIHP and focuses on the three federally mandated EQR activities of compliance determination, validation of performance measures, and validation of performance improvement projects.

On October 24, 2016, CCME sent notification to WellCare that the annual EQR was being initiated (see Attachment 1). This notification included a list of materials required for a desk review and an invitation for a teleconference to allow WellCare to ask questions regarding the EQR process and the desk materials being requested.

The review consisted of two segments. The first was a desk review of materials and documents received on November 7, 2016 and reviewed in the offices of CCME (see Attachment 1). These items focused on administrative functions, committee minutes, member and provider demographics, member and provider educational materials, and the Quality Improvement and Medical Management Programs. Also included in the desk review was a review of credentialing, grievance, utilization, case management, and appeal files.

The second segment was an onsite review conducted on December 15th and 16th at WellCare's office located in Columbia, SC. The onsite visit focused on areas not covered in the desk review or needing clarification. See Attachment 2 for a list of items requested for the onsite visit. Onsite activities included an entrance conference; interviews with WellCare's administration and staff; and an exit conference. All interested parties were invited to the entrance and exit conferences.

FINDINGS

The findings of the EQR are summarized below and are based on the regulations set forth in title 42 of the Code of Federal Regulations (CFR), part 438, and the contract requirements between WellCare and SCDHHS. Strengths, weaknesses and recommendations are identified where applicable. Areas of review were identified as meeting a standard (Met), acceptable but needing improvement (Partially Met), failing a standard (Not Met), Not Applicable, or Not Evaluated, and are recorded on the tabular spreadsheet (Attachment 4).

A. Administration

The Carolinas Center for Medical Excellence (CCME) Administration review focused on WellCare of South Carolina's (WellCare) overall approach to policies and procedures, staffing, information systems, compliance, and confidentiality. WellCare of South Carolina is part of WellCare Health Plans, Inc. WellCare's corporate and South Carolina specific policies and procedures are comprehensive, organized in a consistent manner, and reviewed annually. Kathy Warner serves as plan president and has overall responsibility for day-to-day business activities. Dr. Robert London is the senior medical director located in South Carolina and board certified in obstetrics/gynecology. Organizational charts confirm WellCare has sufficient local and corporate staff to meet the needs of its members.

WellCare submitted a Corporate Compliance Plan that includes a South Carolina specific addendum, Code of Conduct and Business Ethics, and numerous policies and procedures detailing processes used to prevent, detect, and investigate any suspicion of fraud, waste, or abuse. WellCare has a compliance hotline that is well publicized and available to employees, members, and the general public. The Compliance Committee meets quarterly and is chaired by Mark Ruise, director of market compliance.

WellCare's *Member Handbook* contains the *Notice of Privacy Practices*. WellCare trains new employees on compliance, confidentiality, and HIPAA. *Policy SC22 HIP.01.004-ST, Corporate Policy HIPAA*, mentions two timeframes when new employees receive this training; however, this policy does not indicate if employee training occurs prior to having access to protected health information (PHI).

WellCare had a security audit performed by an external third party between June 23, 2016 and July 6, 2016. This audit revealed a number of areas needing improvement. No documentation was provided to show corrective measures are planned. WellCare processes 99.72% of clean claims within 30 days and 99.97% within 90 days. WellCare tested its disaster recovery plan the first quarter of 2016 and met or exceeded all internal requirements.

WellCare received "Met" scores for 97% of the standards in the Administration section as illustrated in *Figure 2, Administration Findings*. The "Partially Met" score is due to WellCare not addressing issues identified during the security audit.

Figure 2: Administration Findings

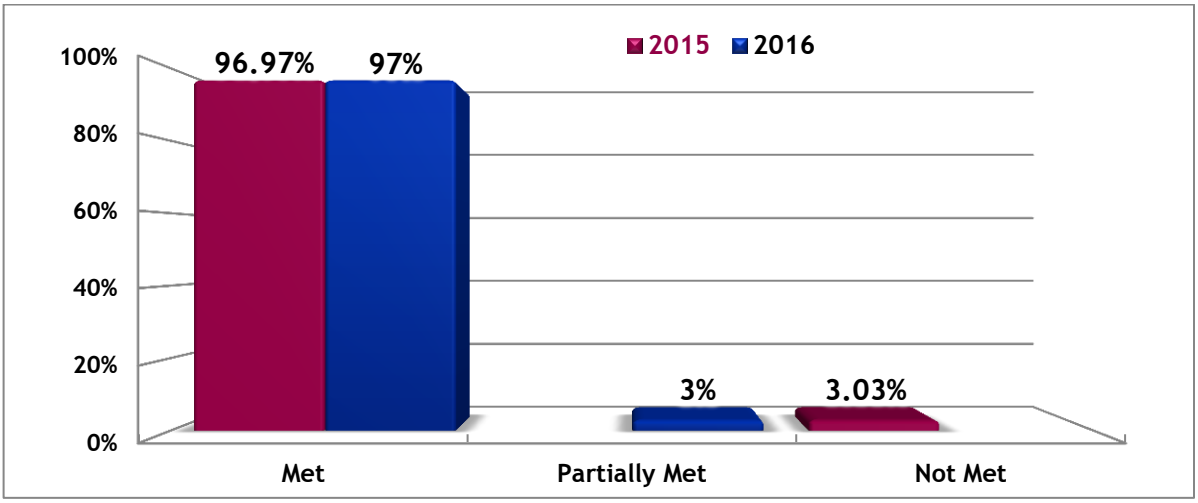


Table 2: Administration Comparative Data

SECTION	STANDARD	2015 REVIEW	2016 REVIEW
Compliance/ Program Integrity	The MCO has policies, procedures, and a Compliance Plan that are consistent with state and federal requirements to guard against fraud and abuse.	Not Met	Met
Management Information Systems	The MCO has policies, procedures and/or processes in place for addressing system and information security and access management.	Met	Partially Met

The standards reflected in the table are only the standards that showed a change in score from 2015 to 2016.

Strengths

- WellCare has a comprehensive Corporate Compliance Plan and multiple policies and procedures that include a Code of Conduct, South Carolina specific requirements for program integrity, and scheduled measures to detect and prevent fraud, waste, and abuse.
- WellCare maintains up-to-date, complete, and tested disaster recovery procedures that define the disaster recovery process.

Weaknesses

- *Policy SC22 HIP.01.004-ST, Corporate Policy HIPAA*, does not state HIPAA training must be completed prior to receiving access to PHI.
- WellCare did not provide documentation to demonstrate the issues reported in the (GuidePoint) data security audit are being addressed.

Quality Improvement Plan

- Document the corrective action measures planned or taken to correct or improve the issues identified in the security audit.

Recommendations

- Include in *Policy SC22 HIP.01.004-ST, Corporate Policy HIPAA*, or other appropriate policy, that HIPAA training is conducted prior to accessing any PHI.

B. Provider Services

CCME conducted a review of all Provider Services policies, procedures, the provider agreement, provider training and educational materials, provider network information, credentialing/recredentialing files, and practice guidelines. The Credentialing Committee is chaired by Dr. Robert London, medical director, and the committee meets monthly. The list of voting committee members provided by WellCare in the desk materials illustrate the committee chair and three network providers with specialties in cardiology, hematology/oncology, and family medicine. However, onsite discussion with Dr. London confirmed that three additional network providers were added to the committee; Dr. Mubarak and Dr. Jayagopalin were added in July 2016, and Dr. Jasper in November 2016. WellCare needs to update the list of Credentialing Committee members to reflect the current committee membership. A quorum is met with a majority of the committee membership in attendance.

The *Credentialing Program Description* provides a broad overview of the credentialing program and additional policies and procedures detail SC credentialing and recredentialing guidelines for practitioners and organizational providers. CCME's review of credentialing and recredentialing files found the files are organized and WellCare provided appropriate documentation.

WellCare conducts an annual review of contracted practitioner office medical records utilizing criteria based on contractual requirements and federal and state regulations. The results of the annual medical record review conducted in 2015 note that WellCare received 650 records (65 providers) of the 720 requested. A total of 57 providers passed

the audit with eight providers (80 records) failing the review. The results documentation does not explain the criteria used to determine a failed score and does not explain what follow-up took place for the providers placed on a corrective action plan. *Policy SC22 HS-QI-005, South Carolina - Medical Record Review*, states the provider is re-audited during the next cycle. During onsite discussion, WellCare was unsure of the process and needs to ensure timely follow-up of non-compliant providers.

Provider Access and Availability Study

As part of the annual EQR process for WellCare, CCME performed a provider access study focused on primary care providers. A list of current providers was given to CCME by WellCare, from which CCME identified a population of 1,276 unique PCPs. CCME pulled a randomly selected sample of 298 providers from this population for the access study. CCME then attempted to contact these providers and ask a series of questions regarding access members have to the contracted providers.

In reference to the results of the *Telephonic Provider Access Study* conducted by CCME, calls were successfully answered 42% of the time (124/298) by personnel at the correct practice, which estimates between 39.11% and 44.11% for the entire population using a 95% Confidence Interval. When compared to last year's results of 46%, this year's rate of answered calls decreased. *Table 3, Provider Access and Availability Study,* presents the sample size and answer rate for the 2015 and 2016 reviews. A Fisher's exact test was conducted to compare the answer rates and the results showed that there was not a statistically significant decrease (p=.28).

Table 3: Provider Access and Availability Study

	Sample Size	Answer Rate	Fisher's exact p-value
2015 Review	300	46%	.28
2016 Review	298	42%	

For those not answered successfully (n=174 calls), 84 (48%) were unsuccessful because the provider was not at the office or phone number listed. Of the 124 successful calls, 99 (80%) of the providers indicated that they accept WellCare, and of the 99 that accept WellCare, 55 (56%) responded that they are accepting new Medicaid patients.

Regarding a screening process for new patients, 34 (60%) of the 57 providers that responded to the item indicated that an application or prescreen was necessary. Of those 34, five (15%) indicated that an application must be filled out whereas eight (24%) require a review a medical records before accepting a new patient, and nine (26%) required both.

When the office was asked about the next available routine appointment, 42 (70%) of the 60 responses met contact requirements.

Figure 3, Provider Services Findings, shows that 94% of the standards in Provider Services received a "Met" score.

Figure 3: Provider Services Findings

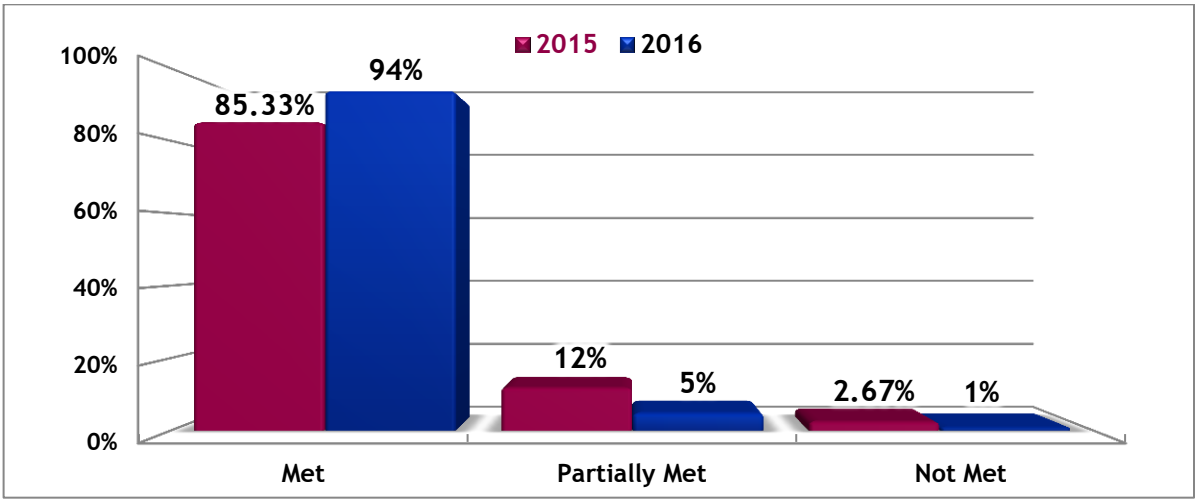


Table 4: Provider Services Comparative Data

SECTION	STANDARD	2015 REVIEW	2016 REVIEW
Credentialing and Recredentialing	Site assessment, including but not limited to adequacy of the waiting room and bathroom, handicapped accessibility, treatment room privacy, infection control practices, appointment availability, office waiting time, record keeping methods, and confidentiality measures.	Partially Met	Met
	Organizational providers with which the MCO contracts are accredited and/or licensed by appropriate authorities.	Partially Met	Met
Adequacy of the Provider Network	Members have a primary care physician located within a 30-mile radius of their residence.	Partially Met	Met

SECTION	STANDARD	2015 REVIEW	2016 REVIEW
Adequacy of the Provider Network	Members have access to specialty consultation from a network provider located within reasonable traveling distance of their homes. If a network specialist is not available, the member may utilize an out-of-network specialist with no benefit penalty.	Met	Partially Met
Provider Education	The MCO formulates and acts within policies and procedures related to initial education of providers.	Not Met	Met
	Billing and reimbursement practices;	Partially Met	Met
	Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by SCDHHS;	Partially Met	Met
Primary and Secondary Preventive Health Guidelines	The MCO assesses practitioner compliance with preventive health guidelines through direct medical record audit and/or review of utilization data.	Partially Met	Met
Clinical Practice Guidelines for Disease and Chronic Illness Management	The MCO assesses practitioner compliance with clinical practice guidelines for disease and chronic illness management through direct medical record audit and/or review of utilization data.	Partially Met	Met
Practitioner Medical Records	The MCO monitors compliance with medical record documentation standards through periodic medical record audit and addresses any deficiencies with the providers.	Met	Partially Met

The standards reflected in the table are only the standards that showed a change in score from 2015 to 2016.

Strengths

- WellCare has added three network providers to their Credentialing Committee in the five months prior to this review.
- Overall, the credentialing program is well-established and the credentialing/ recredentialing files were in good order and contained appropriate information.

Weaknesses

- The list of Credentialing Committee members CCME received in the desk materials was outdated and did not reflect the current voting members of the committee.
- *Policy SC22 OP-NI-001, SC - GeoAccess Reporting*, had the following issues:
    - The policy references a table 2.11 and website links for the *SC Policy and Procedure Guide* for MCOs that are incorrect.
    - Mentions a standard for specialists but does not mention standards for pharmacy, hospitals, or behavioral health.
    - Does not address network access goals used to determine deficiencies.
- A review of the web-based *Provider Directory* showed the language search option was hard to find with no instructions for the user.
- The *Provider Manual* defines appointment access standards but page 102 does not contain the following standard for behavioral health that is listed in the policy, "non-life threatening emergency within 6 hours."
- The provider access study results decreased from the previous year review. The successful answer rate was 42% for the current year and 46% for the previous year.
- The results documentation from the annual medical record review conducted in 2015 does not explain what criteria was used to determine a failed score and does not explain what follow-up took place with the providers placed on a corrective action plan.

Quality Improvement Plans

- Update the list of Credentialing Committee members to reflect the current voting members of the committee.
- Update *Policy SC22 OP-NI-001, SC - GeoAccess Reporting*, to include more detail on the standards used for GEOAccess analysis and include goals used to determine network deficiencies.
- Update the *Provider Manual* to include the appointment access standard, "non-life threatening emergency within 6 hours" that is defined in *Policy SC22 OP-NI-002*.
- Regarding member's access to their providers, identify and address barriers in the update process so that up-to-date contact information is available to members. Create an action plan for ensuring provider contact information is accurate.
- Ensure corrective action is addressed in the medical record review audit results and follow-up is conducted in a timely manner for providers that fail the medical record review.

Recommendations

- Update the web-based *Provider Directory* to include the language search option in a more prominent area and instructions for the user.

C. Member Services

CCME's Member Services review includes policies and procedures, member rights, member materials, and the handling of grievances, member disenrollment, and practitioner changes. WellCare's Member Services call center is available via toll-free telephone number, TTY service, and facsimile Monday through Friday from 8:00 a.m. to 6:00 p.m. Members are able to leave a message for Member Services or speak with the Nurse Advice Line outside of normal business hours, 24 hours a day.

Within 14 days of receiving enrollment information, WellCare provides new members with a *Member Handbook* and additional written information that provides education on WellCare's health plan, programs, services, and benefits. Corresponding information is available on WellCare's website. The member portal of the website allows members to update addresses and phone numbers, request PCP changes, and order over-the-counter items. The *Member Handbook* is written in appropriate language for ease of understanding and contains information required by the *SCDHHS Contract*. CCME noted issues in information presented in the handbook regarding authorizations for care from out-of-network providers, prescriptions written by out-of-network providers, and incomplete information regarding member-initiated for-cause disenrollment requests. In addition, CCME noted discrepancies in benefit limits and copayment information in the benefit grids found in the *Member Handbook*, *Provider Manual*, and on WellCare's website.

Although onsite discussion confirmed WellCare provides appropriate notification to members of changes to services and benefits, CCME found no policy that addresses the requirements and processes for providing this notification. WellCare staff stated during the onsite that a policy is in place; CCME requested a copy of this policy but did not receive a response from WellCare.

WellCare contracts with SPH Analytics, a certified CAHPS® survey vendor, to conduct annual member satisfaction surveys. Survey response rates of 18.6% (Child) and 25% (Adult) are lower than previous year response rates. CCME provided recommendations for increasing survey response rates during the onsite visit. The QIC is involved in generating interventions and initiatives to address problematic areas of member satisfaction.

Documentation of grievance processes and requirements in policies, the *Member Handbook*, *Provider Manual*, and on the website is detailed and contains information necessary for staff and members to understand the grievance process. CCME noted minor

issues, including lack of the grievance filing timeframe in the *Medicaid Grievance Policy* and lack of complete information regarding extending grievance resolution timeframes on the WellCare website. Grievance files are well-documented with timely resolution and thorough documentation is included in the resolution letters. Two files have acknowledgement letters sent outside of the five business-day timeframe.

As noted in *Figure 4, Member Services Findings*, 95% of the standards for Member Services received a score of "Met." Standards scored as "Partially Met" are related to discrepancies in benefit limits and copayment amounts across documents; documentation in the *Member Handbook* about requirements for authorization of out-of-network care and prescriptions, and incomplete information about member-initiated disenrollment; and lack of a policy addressing member notification of changes in services and benefits.

Figure 4: Member Services Findings

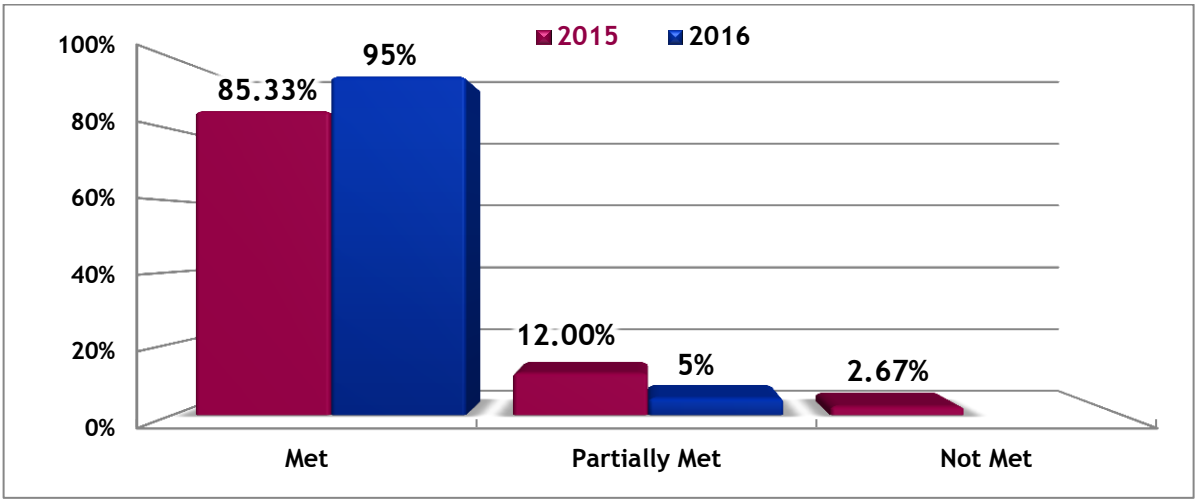


Table 5: Member Services Comparative Data

SECTION	STANDARD	2015 REVIEW	2016 REVIEW
Grievances	The MCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to the procedure for filing and handling a grievance	Partially Met	Met
	Timeliness guidelines for resolution of the grievance as specified in the contract	Partially Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2015 to 2016.

Strengths

- The *Mommy & Baby Matters* booklet provides detailed information on pregnancy, pregnancy prevention, infant care, safety, milestones, and preventive care recommendations.
- Member Services training materials provide comprehensive information and a user-friendly format for staff education.
- The call center statistics for 2016 consistently exceed established goals for abandonment rate, average speed of answer, and service level.

Weaknesses

- Discrepancies in co-payment amounts and benefit limits are noted between the information in the *Member Handbook*, the website, and the *Provider Manual* for the following services:
    - Ambulatory Surgical Center—the *Member Handbook* lists a co-payment of $3.30, but the website and *Provider Manual* state the co-pay is $0.
    - Chiropractic—the *Member Handbook* and *Provider Manual* state there is a limit of 6 visits per year, but the website states the limit is 8 visits per year.
    - DME—the *Member Handbook* lists a co-payment of $3.40, but the website and *Provider Manual* state the co-payment is $0.
    - Eye exams/vision services—the *Member Handbook* lists a $3.30 co-payment for members 19 and 20. The website and *Provider Manual* state the co-payment is $0 for members 19 and 20.
    - FQHC services—the *Member Handbook* states the co-payment is $3.30, but the website and *Provider Manual* list the co-payment as $0.
    - Home health services—the *Member Handbook* co-payment amount is $3.30, but the website and *Provider Manual* list the co-payment as $0.
    - Physician services—the *Member Handbook* co-payment amount is $3.30, but the website and *Provider Manual* state $0.
    - Podiatry services—the *Member Handbook* states a $1.15 co-payment, but the website and *Provider Manual* state $0.
    - RHC Services—the *Member Handbook* lists a co-payment of $3.30, but the website and *Provider Manual* state $0.
- A statement in the *Member Handbook* appears to state the PCP can approve out-of-network care without seeking an authorization from WellCare, and can result in confusion for members.

- The *Member Handbook* states, "Prescriptions must be written by one of our network providers." It further states, "Your PCP must approve a prescription from an out-of-network provider." Onsite discussion confirmed prescriptions may be written by out-of-network providers, and there is no requirement that the PCP must approve those prescriptions.
- The *Member Handbook* includes brief information on member-requested disenrollment, but does not clearly describe for-cause disenrollment requests or provide examples of reasons a member may request disenrollment for cause. Refer to the *SCDHHS Contract, Section 3.3.2.4.3*.
- The *SCDHHS Contract, Section 11.2.9.1*, requires SCDHHS' fraud hotline, fraud email address, and toll-free line to be placed in a prominent position in all member communications so that members may easily identify the information. This information, located on pages 65-66 of the *Member Handbook* document, is not displayed in a prominent location.
- *Policy SC22 HS-UM-017, South Carolina - Cont'd Care with Termed Provider and Not to Members of Specialist Term*, defines the timeframe for member notification of a PCP's termination, but does not specify the timeframe for notification of a specialist's termination.
- The *SCDHHS Policy & Procedure Guide, Appendix 1*, states members have the right to receive notice of any significant changes in the benefits package at least 30 days before the intended effective date of the change. However, no policy was submitted that addresses member notification of changes to services or benefits. Onsite discussion confirmed WellCare is following appropriate processes.
- *Policy SC22 SM-004, South Carolina - Medicaid Written Member Materials and Marketing Materials Review and Approval Process, Addendum A—South Carolina*, does not define the method used to determine reading level of member materials. Onsite discussion confirmed WellCare uses the Flesch-Kincaid method to determine reading level.
- The *Member Handbook* presents information on disease management programs for asthma, diabetes, coronary artery disease, congestive heart failure, chronic obstructive pulmonary disease, hypertension, smoking cessation, and weight management. The *Provider Manual* information on disease management programs does not include weight management.
- Member satisfaction survey response rates of 18.6% (Child) and 25% (Adult) were lower than the previous year's (2015) rates of 26.4% (Child) and 30.8% (Adult).
- *Policy SC22 OP-GR-001, South Carolina - Medicaid Grievance Policy*, does not include the timeframe for filing a grievance. The *Member Handbook*, the *Provider Manual*, and

the WellCare website define the timeframe as within 30 days of the date of the event that caused dissatisfaction.

- The WellCare website states that members may request an extension of the grievance resolution timeframe, but does not indicate that WellCare may initiate an extension and under what conditions.
- Review of grievance files reflected thorough documentation of members' complaints, investigation, and resolution. Resolutions met timeliness requirements; however 2 acknowledgement letters are not in compliance with the 5 business-day requirement for acknowledgement.

Quality Improvement Plans

- Revise the benefit grids in the *Member Handbook*, *Provider Manual*, and website so that information on benefits limits and copayment amounts is consistent.
- Update the statement in the *Member Handbook* to indicate that out-of-network care must be authorized by WellCare.
- Correct the erroneous information that prescriptions must be written by network providers and PCPs must approve prescriptions from out-of-network providers in the *Member Handbook*.
- Revise the *Member Handbook* to provide detailed information about for-cause disenrollment requests, including examples of reasons members may request for-cause disenrollment.
- Include in a policy the requirements and process for notifying members of changes to services and benefits.

Recommendations

- Ensure information on reporting fraud, waste, and abuse, appear in a prominent position in the *Member Handbook*.
- Add the timeframe for member notification of a specialist's termination from the network to *Policy SC22 HS-UM-017*.
- Include the method used to determine readability level of member materials in *Policy SC22 SM-004*.
- Include weight management in the list of disease management programs in the *Provider Manual*.
- Continue working with vendors to increase response rates for the child and adult member satisfaction surveys.
- Ensure *Policy SC22-OP-CS-001* is updated to include the 30-day timeframe for filing a grievance.

- Add information to the WellCare website that WellCare may initiate an extension of the grievance resolution timeframe and under what circumstances this may occur. Refer to the *SCDHHS Contract, Section 9.7.2.4.1.*
- Ensure grievance acknowledgement letters are sent within required timeframes.

D. Quality Improvement

WellCare's *2016 Medicaid Quality Improvement (QI) Program Description* outlines the process for measuring and improving the care and services received by its members and their providers. The program description includes the program's goals, objectives, structure, and scope. The program description includes a list of delegated entities and the respective delegated activities. This list only included nine delegates which is different from the list of 19 delegates provided with the desk materials. The Senior Medical Director, Dr. Robert London, supports and oversees the clinical aspects of the QI department. The ten QI department staff members report to the senior QI director. The QI director position is listed as a vacant position on the organization chart. The senior QI director is responsible for administering the duties of the QI director until the vacancy is filled.

The Quality Improvement Committee (QIC) provides oversight and approval of all planned activities. According to the 2016 QI program description, the QIC is chaired by the senior medical director, meets at least quarterly, and a quorum is determined by at least four voting members. A review of the committee minutes found the committee met as outlined in the committee charter and a quorum was always present. The minutes do not reflect that the senior medical director chaired the meetings. Staff interviewed during the onsite visit indicated this was an error in the committee minutes.

The Utilization Medical Advisory Committee (UMAC) oversees all clinical QI, utilization management, and behavioral health activities. According to the *QI Program Description*, the UMAC provides an avenue for which network providers can offer recommendations about the health plans QI and utilization management activities. The committee meets at least quarterly, and only the physician members have voting privileges. The attendance by network providers continues to be poor; however, two new network providers were recruited in May.

Provider compliance with WellCare's clinical and preventive practice guidelines is included in the QI program description and in policy *SC22 HS-QI-009, South Carolina - Provider Clinical Practice Guidelines and Preventive Health Guidelines*. Monitoring results are not included in the 2015 program evaluation or on the 2015 and 2016 work plans. WellCare only provided an example report with some analysis in the desk materials.

Performance Measure Validation

CCME conducted a validation review of the HEDIS® performance measures following the protocols developed by CMS. This process assesses the production of these measures by the plan to confirm reported information is valid.

WellCare uses Inovalon, a certified software organization, to calculate HEDIS rates and verify the measures are fully compliant and consistent with CMS protocol requirements. Comparison from the previous to the current year reveal a strong increase in Use of First Line Psychosocial Care for Children and Adolescent on Antipsychotics with a 48% increase for 6-11 year olds and 48% increase for 12-17 year olds. The most problematic measures were the Immunization Rates with decreases of over 10% for several of the measures. All immunization rates decreased. The HbA1C Poor Control rate increased over 10% and the Adult BMI Assessment rate decreased almost 10%. All relevant HEDIS performance measures are detailed in *Table 6: HEDIS Performance Measure Data*.

Table 6: HEDIS Performance Measure Data

MEASURE/DATA ELEMENT	HEDIS 2014	HEDIS 2015	PERCENTAGE POINT DIFFERENCE
Effectiveness of Care: Prevention and Screening			
Adult BMI Assessment (aba)	81.84%	71.92%	-9.92%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)			
BMI Percentile	50.61%	54.26%	+3.65%
Counseling for Nutrition	45.26%	45.50%	+0.24%
Counseling for Physical Activity	42.34%	40.39%	-1.95%
Childhood Immunization Status (cis)			
DTaP	70.32%	57.65%	-12.67%
IPV	86.62%	74.23%	-12.39%
MMR	84.67%	78.32%	-6.35%
HiB	82.48%	68.11%	-14.37%
Hepatitis B	84.43%	73.98%	-10.45%
VZV	85.89%	77.81%	-8.08%
Pneumococcal Conjugate	72.75%	58.42%	-14.33%
Hepatitis A	80.29%	73.47%	-6.82%

MEASURE/DATA ELEMENT	HEDIS 2014	HEDIS 2015	PERCENTAGE POINT DIFFERENCE
Rotavirus	70.32%	54.59%	-15.73%
Influenza	36.98%	28.32%	-8.66%
Combination #2	63.99%	51.79%	-12.20%
Combination #3	61.80%	49.74%	-12.06%
Combination #4	58.39%	48.47%	-9.92%
Combination #5	52.07%	40.82%	-11.25%
Combination #6	28.95%	21.17%	-7.78%
Combination #7	50.12%	39.80%	-10.32%
Combination #8	28.22%	20.92%	-7.30%
Combination #9	27.25%	18.37%	-8.88%
Combination #10	26.76%	18.11%	-8.65%
Immunizations for Adolescents (ima)			
Meningococcal	60.39%	55.11%	-5.28%
Tdap/Td	72.13%	72.82%	+0.69%
Combination #1	58.68%	54.36%	-4.32%
Human Papillomavirus Vaccine for Female Adolescents (hpv)	12.90%	12.65%	-0.25%
Lead Screening in Children (lsc)	63.28%	59.11%	-4.17%
Breast Cancer Screening (bcs)	53.08%	52.97%	-0.11%
Cervical Cancer Screening (ccs)	57.40%	61.29%	+3.89%
Chlamydia Screening in Women (chl)			
16-20 Years	53.67%	52.81%	-0.86%
21-24 Years	60.81%	62.53%	+1.72%
Total	55.23%	55.17%	-0.06%
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (cwp)	72.64%	76.41%	+3.77%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	34.59%	23.21%	-11.38%
Pharmacotherapy Management of COPD Exacerbation (pce)			
Systemic Corticosteroid	47.60%	54.95%	+7.35%
Bronchodilator	75.96%	75.23%	-0.73%
Medication Management for People With Asthma (mma)			

MEASURE/DATA ELEMENT	HEDIS 2014	HEDIS 2015	PERCENTAGE POINT DIFFERENCE
5-11 Years - Medication Compliance 50%	45.45%	49.06%	+3.61%
5-11 Years - Medication Compliance 75%	20.35%	20.63%	+0.28%
12-18 Years - Medication Compliance 50%	44.38%	39.41%	-4.97%
12-18 Years - Medication Compliance 75%	16.85%	15.27%	-1.58%
19-50 Years - Medication Compliance 50%	36.00%	53.62%	+17.62%
19-50 Years - Medication Compliance 75%	14.00%	21.74%	+7.74%
51-64 Years - Medication Compliance 50%	NA	65.22%	NA
51-64 Years - Medication Compliance 75%	NA	43.48%	NA
Total - Medication Compliance 50%	44.54%	46.99%	+2.45%
Total - Medication Compliance 75%	19.12%	19.84%	+0.72%
Asthma Medication Ratio (amr)			
5-11 Years	75.30%	72.13%	-3.17%
12-18 Years	60.10%	65.13%	+5.03%
19-50 Years	36.84%	37.00%	+0.16%
51-64 Years	NA	60.00%	NA
Total	63.67%	64.58%	+0.91%
Effectiveness of Care: Cardiovascular Conditions			
Controlling High Blood Pressure (cbp)	48.66%	38.93%	-9.73%
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	NA	76.92%	NA
Statin Therapy for Patients With Cardiovascular Disease (spc)			
Received Statin Therapy - 21-75 years (Male)	NA	70.07%	NA
Statin Adherence 80% - 21-75 years (Male)	NA	50.49%	NA
Received Statin Therapy - 40-75 years (Female)	NA	69.44%	NA
Statin Adherence 80% - 40-75 years (Female)	NA	45.33%	NA
Received Statin Therapy - Total	NA	69.80%	NA
Statin Adherence 80% - Total	NA	48.31%	NA
Effectiveness of Care: Diabetes			

MEASURE/DATA ELEMENT	HEDIS 2014	HEDIS 2015	PERCENTAGE POINT DIFFERENCE
Comprehensive Diabetes Care (cdc)			
Hemoglobin A1c (HbA1c) Testing	84.18%	82.00%	-2.18%
HbA1c Poor Control (>9.0%)	47.69%	58.15%	+10.46%
HbA1c Control (<8.0%)	43.55%	36.50%	-7.05%
HbA1c Control (<7.0%)	NA	NA	NA
Eye Exam (Retinal) Performed	34.79%	28.71%	-6.08%
Medical Attention for Nephropathy	81.27%	88.32%	+7.05%
Blood Pressure Control (<140/90 mm Hg)	51.58%	44.53%	-7.05%
Statin Therapy for Patients With Diabetes (spd)			
Received Statin Therapy	NR	54.37%	NA
Statin Adherence 80%	NR	45.45%	NA
Effectiveness of Care: Musculoskeletal Conditions			
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (art)	58.33%	67.31%	+8.98%
Effectiveness of Care: Behavioral Health			
Antidepressant Medication Management (amm)			
Effective Acute Phase Treatment	34.42%	35.92%	+1.50%
Effective Continuation Phase Treatment	20.33%	21.93%	+1.60%
Follow-Up Care for Children Prescribed ADHD Medication (add)			
Initiation Phase	35.26%	50.31%	+15.05%
Continuation and Maintenance (C&M) Phase	51.92%	59.29%	+7.37%
Follow-Up After Hospitalization for Mental Illness (fuh)			
30-Day Follow-Up	7.62%	8.09%	+0.47%
7-Day Follow-Up	2.65%	6.25%	+3.60%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd)	85.19%	71.57%	-13.62%
Diabetes Monitoring for People With Diabetes and Schizophrenia (smd)	61.97%	60.00%	-1.97%

MEASURE/DATA ELEMENT	HEDIS 2014	HEDIS 2015	PERCENTAGE POINT DIFFERENCE
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (smc)	NA	77.78%	NA
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (saa)	59.32%	64.29%	+4.97%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)			
1-5 Years	NA	25.00%	NA
6-11 Years	14.52%	21.43%	+6.91%
12-17 Years	23.40%	20.93%	-2.47%
Total	19.62%	21.21%	+1.59%
Effectiveness of Care: Medication Management			
Annual Monitoring for Patients on Persistent Medications (mpm)			
ACE Inhibitors or ARBs	88.22%	88.64%	+0.42%
Digoxin	NA	60.00%	NA
Diuretics	88.67%	88.93%	+0.26%
Total	88.09%	88.59%	+0.50%
Effectiveness of Care: Overuse/Appropriateness			
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	NR	3.42%	NA
Appropriate Treatment for Children With URI (uri)	84.34%	87.09%	+2.75%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)	25.00%	28.72%	+3.72%
Use of Imaging Studies for Low Back Pain (lbp)	73.61%	74.03%	+0.42%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (apc)			
1-5 Years	NA	0.00%	NA
6-11 Years	0.00%	0.00%	0.00%
12-17 Years	1.64%	1.56%	-0.08%
Total	0.91%	0.97%	+0.06%
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (aap)			

MEASURE/DATA ELEMENT	HEDIS 2014	HEDIS 2015	PERCENTAGE POINT DIFFERENCE
20-44 Years	73.64%	75.63%	+1.99%
45-64 Years	84.53%	85.56%	+1.03%
65+ Years	NA	100.00%	NA
Total	77.12%	78.93%	+1.81%
Children and Adolescents' Access to Primary Care Practitioners (cap)			
12-24 Months	90.78%	94.78%	+4.00%
25 Months - 6 Years	82.70%	84.17%	+1.47%
7-11 Years	89.31%	90.11%	+0.80%
12-19 Years	85.71%	86.35%	+0.64%
Annual Dental Visit (adv)			
2-3 Years	NR	0.53%	NA
4-6 Years	NR	0.42%	NA
7-10 Years	NR	0.13%	NA
11-14 Years	NR	0.11%	NA
15-18 Years	NR	0.40%	NA
19-20 Years	NR	0.15%	NA
Total	NR	0.27%	NA
Initiation and Engagement of AOD Dependence Treatment (iet)			
Initiation of AOD Treatment: 13-17 Years	41.60%	29.21%	-12.39%
Engagement of AOD Treatment: 13-17 Years	21.60%	19.10%	-2.50%
Initiation of AOD Treatment: 18+ Years	35.84%	36.26%	+0.42%
Engagement of AOD Treatment: 18+ Years	7.13%	7.32%	+0.19%
Initiation of AOD Treatment: Total	36.45%	35.73%	-0.72%
Engagement of AOD Treatment: Total	8.67%	8.20%	-0.47%
Prenatal and Postpartum Care (ppc)			
Timeliness of Prenatal Care	86.62%	82.65%	-3.97%
Postpartum Care	61.56%	63.27%	+1.71%

MEASURE/DATA ELEMENT	HEDIS 2014	HEDIS 2015	PERCENTAGE POINT DIFFERENCE
Call Answer Timeliness (cat)	89.78%	85.61%	-4.17%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)			
1-5 Years	NA	0.00%	NA
6-11 Years	NA	73.68%	NA
12-17 Years	11.63%	60.00%	+48.37%
Total	15.38%	63.33%	+47.95%
Utilization			
Frequency of Ongoing Prenatal Care (fpc)			
<21 Percent	8.03%	6.38%	-1.65%
21-40 Percent	1.46%	3.06%	+1.60%
41-60 Percent	4.38%	5.10%	+0.72%
61-80 Percent	14.11%	14.54%	+0.43%
81+ Percent	72.02%	70.92%	-1.10%
Well-Child Visits in the First 15 Months of Life (w15)			
0 Visits	1.26%	5.35%	+4.09%
1 Visit	2.51%	2.68%	+0.17%
2 Visits	5.53%	4.14%	-1.39%
3 Visits	7.29%	3.89%	-3.40%
4 Visits	13.82%	13.38%	-0.44%
5 Visits	19.85%	18.98%	-0.87%
6+ Visits	49.75%	51.58%	+1.83%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (w34)	61.48%	57.14%	-4.34%
Adolescent Well-Care Visits (awc)	35.28%	33.82%	-1.46%

Performance Improvement Project Validation

CCME completed validation of the performance improvement projects (PIPs) in accordance with the protocol developed by CMS, *EQR Protocol 3: Validating Performance*

Improvement Projects Version 2.0, September 2012. The protocol validates components of the project and its documentation to provide an assessment of the overall project study design and methodology. The components assessed are:

- Study topic(s)
- Study question(s)
- Study indicator(s)
- Identified study population
- Sampling methodology (if used)
- Data collection procedures
- Improvement strategies

Two projects were validated using the CMS Protocol for Validation of Performance Improvement Projects. One of the two projects was submitted last year (Child Healthcare- Parent/Caregiver member Satisfaction) and validated again this year. *Table 7, Performance Improvement Project Validation Scores,* includes the scores and results for each PIP.

TABLE 7: Performance Improvement Project Validation Scores

PROJECT	2016 VALIDATION SCORE	2015 VALIDATION SCORE
Child Healthcare- Parent/Caregiver Satisfaction (Non Clinical)	95% High Confidence in Reported Results	86% Confidence in Reported Results
Improving Hemoglobin A1C Testing (Clinical)	94% High Confidence in Reported Results	Not previously validated

All projects were chosen based on sound data analysis and provided rationale. CCME identified two issues in the documentation. The first issue is related to the documentation of the HEDIS specifications used for each measurement in the Child Healthcare PIP. On page eight there is detailed information on the baseline measurement including the data analysis process, HEDIS specifications used, the rate, and analysis of the rate. The documentation does not have the HEDIS specification version for the sampling for remeasurement 1 and remeasurement 2. The second issue is found in the hemoglobin A1C testing PIP. The name and qualifications of the personnel who are pulling the data from the claims/files are not listed on page six of the documentation.

The two projects met the validation protocol requirements. The following table lists the specific errors by project along with recommendations.

TABLE 8: Performance Improvement Project Errors and Recommendations

Project	Section	Reasoning	Recommendation
Child Healthcare-Parent/Caregiver Satisfaction (Non Clinical)	Did the instruments for data collection provide for consistent accurate data collection over the time periods studied?	It is documented that HEDIS 2014 specifications were followed for the baseline measurement. The documentation is not clear about which HEDIS specs were used for the 2015 and 2016 measurement years.	Clearly document the HEDIS specifications volume/version used for each remeasurement period.
Improving Hemoglobin A1C Testing (Clinical)	Were qualified staff and personnel used to collect the data?	Study leader was listed in the documentation but staff used to collect/pull data was not listed.	Include staff and qualifications of staff who are pulling and collecting data in section D2.

Details of the validation of the performance measures and performance improvement projects may be found in the *CCME EQR Validation Worksheets, Attachment 3*.

Figure 5, Quality Improvement Findings, indicate that 100% of the standards received a "Met" score.

Figure 5: Quality Improvement Findings

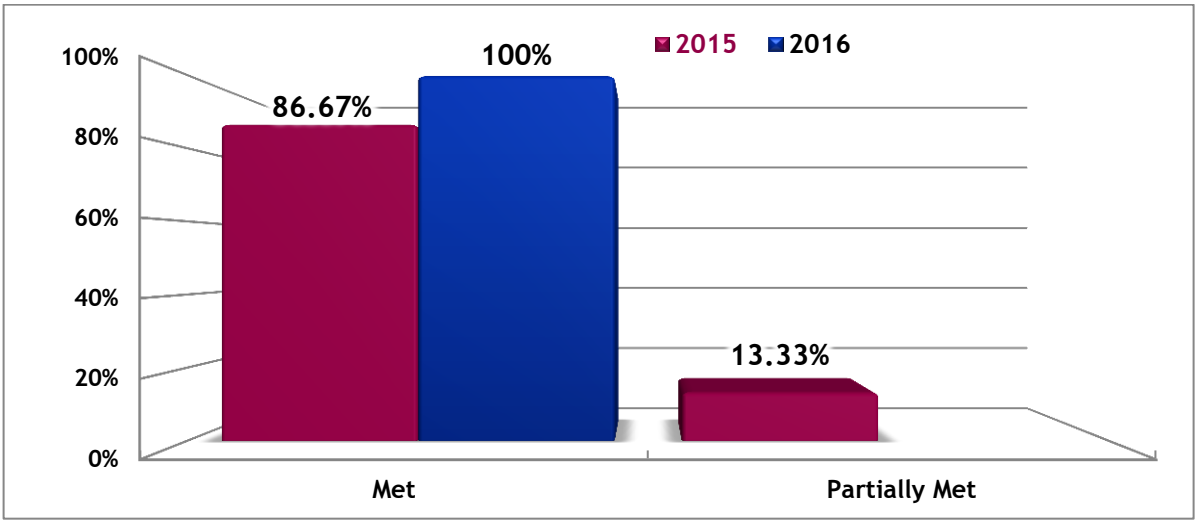


TABLE 9: Quality Management Comparative Data

SECTION	STANDARD	2015 REVIEW	2016 REVIEW
Quality Improvement Committee	The composition of the QI Committee reflects the membership required by the contract	Partially Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2015 to 2016.

Strengths

- Network provider attendance at the Utilization Medical Advisory Committee continues to be poor; however, two new providers were added in May.

Weaknesses

- The monitoring of provider compliance with the clinical and preventive practice guidelines is not included in the 2015 program evaluation or in the 2015 and 2016 work plans. WellCare only provided an example report with some analysis in the desk materials.
- The minutes CCME reviewed are well documented. CCME found errors regarding who chaired the Quality Improvement Committee. According to some minutes, the meeting was chaired by the medical director and in others the meeting was chaired by the director of quality improvement.

- The most problematic performance measures were the Immunization Rates with decreases of over 10% on several measures. All immunization rates have decreased from 2014 rates. The HbA1C Poor control rate increased over 10% and the Adult BMI Assessment rate decreased almost 10%.

Recommendations

- The monitoring of provider compliance with clinical and preventive practice guidelines should be conducted annually per WellCare's procedure, SC22 HS-QI-009-PR-001.
- Ensure the Quality Improvement Committee is always chaired by the medical director or a designee and that this is documented in committee minutes.
- WellCare should consider specific ways to address HEDIS rates that are not progressing positively.

E. Utilization Management

CCME's Utilization Management (UM) review includes a review of policies and procedures, the program descriptions for Utilization Management, Case and Disease Management, and approval, denial, appeals and case management files. WellCare's utilization and case management program descriptions are well-written and include the scope and goals of each program. The policies and procedures related to UM functions are very detailed and clearly define the criteria used when making utilization decisions. WellCare medical directors performing UM reviews represent a variety of specialties.

WellCare has developed a program to identify High Performing Physicians Groups using both quality and cost metrics. The goal is to reward qualifying providers financially for improving performance in these areas. There is no indication that this program offers unique authorization arrangements to providers based on improvements in quality. Onsite discussion confirmed WellCare has not documented such a program because they have not identified any providers who would qualify for such a program. According to *SCDHHS Contract, Section 8.4.2.7*, the health plan is required to develop a preferred provider program based on quality resulting in the provider becoming eligible for special considerations when requesting service authorizations.

WellCare has expanded the scope of case management by providing short-term transitional care and services that make sure members have access to care necessary for a successful transition from one level of care to another, or from one level of care to home. Services can be arranged quickly to meet a crisis and may be provided by nurses, social workers, community health workers, and care coordinators. Dr. London, senior medical director, is also advancing a telemedicine program for South Carolina.

The Pharmacy Lock-In Program requires the plan to review members in the program annually. The frequency of this review is not documented consistently and onsite discussion revealed WellCare may not be conducting the reviews.

As noted in *Figure 6, Utilization Management Findings*, WellCare received a "Met" score for 92% of the standards. Scores of "Partially Met" are due to an incomplete preferred provider program; inconsistent pharmacy policies; and documents stating that written appeals following an oral request must be submitted within 10 days.

Figure 6: Utilization Management Findings

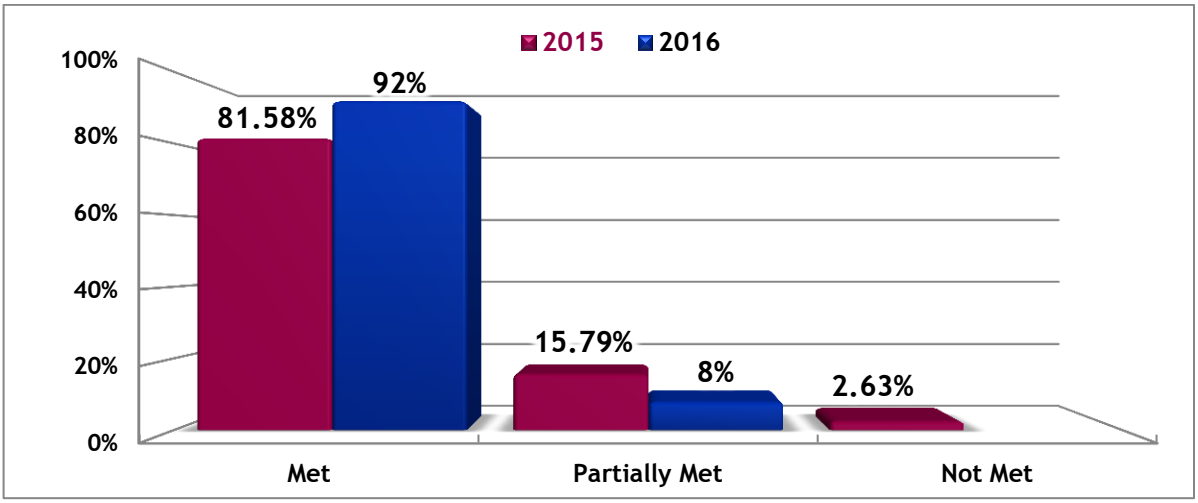


TABLE 10: Utilization Management Comparative Data

SECTION	STANDARD	2015 REVIEW	2016 REVIEW
The Utilization Management Program	The MCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to timeliness of UM decisions, initial notifications, and written (or electronic) verification	Partially Met	Met
Medical Necessity Determinations	Coverage of hysterectomies, sterilizations and abortions is consistent with state and federal regulations	Partially Met	Met

SECTION	STANDARD	2015 REVIEW	2016 REVIEW
Denials	Denial decisions are promptly communicated to the provider and member and include the basis for the denial of service and the procedure for appeal	Partially Met	Met
Appeals	The MCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an action by the MCO in a manner consistent with contract requirements	Not Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2015 to 2016.

Strengths

- WellCare submitted program descriptions for Utilization Management, Case Management, and Disease Management that include the scope and goals of the programs.
- CCME's approval, denial, appeal, and case management file review conclude that WellCare meets timeliness guidelines, uses appropriately trained physician reviewers, requests additional information when needed, and provides notices to members and providers as required.

Weaknesses

- *Policy SC22 HS-UM-025, Service Authorization Decisions*, states that, WellCare will decide urgent pre-service authorization decisions within 72 hours after the receipt of the request and WellCare, a member, or a provider can extend the 72 hour timeframe by 48 hours. The policy does not include information or inform the reader that according to *Federal Regulation § 438.210 (d) (2) (ii)* and *SCDHHS Contract, Section 8.7.3,* the extension for expedited authorizations is 14 days.
- There is no indication that the program WellCare uses to encourage providers toward improved quality offers unique authorization arrangements to providers.
- *Policy SC22 HS-UM-007, South Carolina-Interrater Reliability (IRR),* states the benchmark for passing is 80%; however, the *2016 UM Program Description*, page 12, indicates the benchmark for IRR is 85%.
- *Policy SC22 RX-003, Emergency Medication Overrides,* states members are allowed one emergency override per medication within a 365 day period. Onsite discussion confirmed one emergency override annually is incorrect.

- Page 2 of *Policy SC22 RX-005, SC Pharmacy Lock-In Program,* and page 109 of the *Provider Manual* state members in the Lock-In Program are reviewed by the P&T Committee; however different timeframes for review are documented. CCME found no evidence of review in the P&T Committee minutes.
- WellCare acknowledges member appeal requests within 5 business days; however the *Provider Manual* does not include the timeframe to acknowledge appeals.
- *The SCDHHS Contract, Section 9.1.4.4.1* states written confirmation of all oral requests must be received by the contractor within the timeframe established for the resolution of the appeal. *Policy SC22 HS-AP-002, Member Appeals Policy,* states written confirmation of all oral appeal requests must be received by WellCare within 30 calendar days of the oral request or the appeal may be denied by WellCare. The documents listed below state this written request must be received within 10 days of filing an oral appeal:
    - The *Member Handbook* states members must be sure to follow oral requests with a written statement within 10 calendar days of requesting the appeal orally.
    - The *Provider Manual* states an oral request must be followed by a written appeal within 10 calendar days of the oral filing.
    - The *WellCare Denial Drug Utilization Form* states a phone request must be followed up in writing within 10 days to be valid.
    - The notice of action and acknowledgement letters state an oral appeal request must be followed with a written request within 10 calendar days of the oral request.
    - The Pharmacy Appeals Acknowledgement letter states the written request must be mailed to WellCare within 10 calendar days.
- *Policy SC22 HS-AP-002 Member Appeals Policy*, and *RX-012, Pharmacy Appeals,* contain an incomplete sentence that does not meet *Federal Regulation § 438.406 (a) (3) (B)*; the sentence should read, "A grievance of a denial of an expedited resolution of an appeal."

Quality Improvement Plan

- Update the High Performing Physicians Group program to include rewarding providers with special considerations when requesting service authorizations as detailed in *SCDHHS Contract, Section 8.4.2.7.*
- Update *Policy SC22 RX-003* by removing the limit on emergency medication overrides.
- Update *Policy SC22 RX-005* to include the correct timeframe for pharmacy lock-in member reviews and a process for ensuring annual reviews are conducted.
- Update the *Provider Manual* to include content that WellCare acknowledges the receipt of appeals in writing within 5 business days.

- Ensure the process defined in the appeals policy aligns with wording used in other documents to request written follow-up to an oral appeal, and that it does not imply that filing must be in writing within 10 calendar days.

Recommendations

- Update *Policy SC22 HS-UM-025* to reflect WellCare's process of changing an expedited authorization request to standard if the member requests an extension, and that a member could have a 14 day extension if requested. Update related documents as needed to be consistent.
- Update the *UM Program Description* to be consistent with *Policy SC22 HS-UM-007* regarding the benchmark score for IRR.
- Update *Policy SC22 HS-AP-002* by removing item 2 from the list on page 3 and replacing it with the correct language from *Federal Regulation* § 438.406 (a) (3) (B).

F. Delegation

CCME's delegation review found WellCare has written agreements with all entities performing delegated services and the agreements outline the responsibilities of the delegated entity. Many of the delegations are corporate contracts that provide support to WellCare and addendums define any state specific contract requirements. The WellCare delegated services are defined in the following table.

Table 11: Delegated Entities and Services

Service	Delegated Entities
UM	Advanced Medical Review; CareCore National, LLC (also known as EviCore)
UM	Behavioral Health - Focus Health
Nurse Line	CareNet
Pharmacy	CVS
Customer Service	Teleperformance
Crisis Line	Health Integrated, Inc.
Case Management	Alere
Vision	March Vision

Credentialing	Integra Partners; Linkia, LLC; Mary Black Health Network; Preferred Care of Aiken; Provider HealthLink of South Carolina, LLC; Regional Health; AU Health, formally GA Regents (MCG Health); and Greenville Hospital System Proaxis Therapy

The review of delegation oversight conducted by WellCare indicates two areas needing improvement. WellCare is conducting reviews as required by *the SCDHHS Contract*; however, reviews are not conducted yearly for some of the delegated entities. Corrective action plans (CAPS) for delegated entities are not always completed within timeframes found in *Procedure SC22 CP-007, Delegation Oversight*.

The chart below shows that one standard in Delegation received a "Met" score and the other standard received a "Partially Met" score.

Figure 7: Delegation Findings

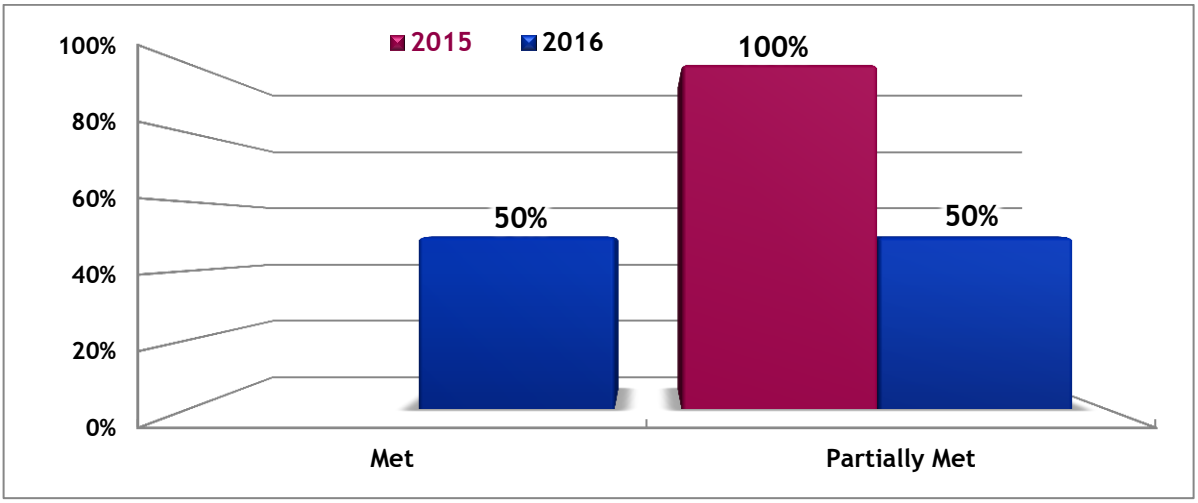


TABLE 12: Delegation Comparative Data

SECTION	STANDARD	2015 REVIEW	2016 REVIEW
Delegation	The MCO has written agreements with all contractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions	Partially Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2015 to 2016.

Weaknesses

- *Policy SC22 CP-AO-007, SC – Delegation Oversight, Addendum D,* incorrectly states that routine visits should be scheduled within 4 – 6 weeks when the *SCDHHS Contract, Section 6.2.2.1.2.1* states a timeframe of four weeks.
- The following Issues relate to credentialing delegation oversight:
    - Integra Partners and Linkia, LLC annual delegation audits did not include credentialing file review for SC. Onsite discussion confirmed this was an oversight.
    - AU Health (formally GA Regents (MCG Health)) annual review audit indicated "N/A – GA licensed" for the ownership disclosure form. Onsite discussion confirmed WellCare was unaware the ownership disclosure form (1514) was required for providers not located in SC that were being credentialed under the SC Contract.
    - Minutes from the 4/5/16 Delegation Oversight Committee showed a pre-delegation audit completed for Roper St. Francis; however, Roper St. Francis was not listed as a delegated entity.
- Some CAPs reviewed were not completed within the timeframe specified in the *Procedure SC22 CP-007, SC – Delegation Oversight*.
- Onsite discussion confirmed that annual oversight of delegated entities is behind schedule.

Quality Improvement Plans

- Update *Policy SC22 CP-AO-007* to reflect the correct standard for routine appointments.
- Ensure files are reviewed for entities in SC that have delegated credentialing.
- Ensure ownership disclosure forms are collected for all entities where credentialing is delegated for SC.
- Update the list of delegated entities to reflect all delegated activities.

Recommendations

- Update *Policy SC22 CP-007, Delegation Oversight Procedure,* to include any changes in the CAP process, including changes to the timeframe to resolve CAPs, if applicable.
- Implement a procedure that ensures delegation oversight occurs at least once per year as required by the contract.

G. State Mandated Services

The CCME review of state mandated services finds that WellCare provides core benefits required by the *SCDHHS Contract*.

WellCare's Early Periodic Screening Diagnosis and Treatment (EPSDT) Program includes all required components of EPSDT services for members up to age 21. Members are encouraged to participate in recommended services in various ways, including the *Member Handbook*, mailings, and reminders. In addition, customer service representatives are able to view care gaps when interacting with members and are encouraged to remind the member of needed services and assist with appointment scheduling.

Upon contracting with WellCare, providers are notified of EPSDT Program requirements via the *Provider Manual*, in provider orientation sessions, and by annual *Provider Manual* updates. Network providers receive monthly reports of members who are not compliant with the EPSDT Program, and providers can access gaps reports via the WellCare provider portal. Provider compliance with member monitoring, tracking, and follow-up is assessed by QI department staff during annual medical record review audits and while monitoring claims and encounter data.

As noted in *Figure 8, State Mandated Services,* WellCare receives a score of "Met" for 100% of the standards.

Figure 8: State Mandated Services

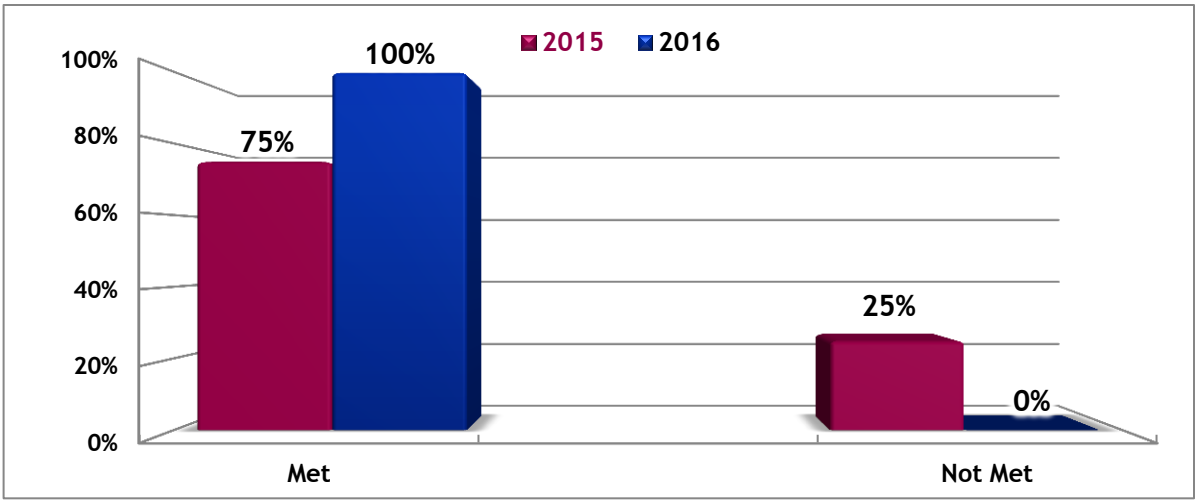


TABLE 13: State Mandated Services Comparative Data

SECTION	STANDARD	2015 REVIEW	2016 REVIEW
State-Mandated Services	The MCO addresses deficiencies identified in previous independent external quality reviews	Not Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2015 to 2016.

ATTACHMENTS

- Attachment 1: Initial Notice, Materials Requested for Desk Review
- Attachment 2: Materials Requested for Onsite Review
- Attachment 3: EQR Validation Worksheets
- Attachment 4: Tabular Spreadsheet

A. Attachment 1: Initial Notice, Materials Requested for Desk Review

October 24, 2016

Kathy Warner
Chief Operating Officer
WellCare of South Carolina
200 Center Point, Suite 180
Columbia, SC 29210

Dear Ms. Warner:

At the request of the South Carolina Department of Health and Human Services (SCDHHS) this letter serves as notification that the 2016 External Quality Review (EQR) of WellCare is being initiated. An external quality review (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) is required by your contract with SCDHHS in relation to your organization's administration of a managed care program for Medicaid recipients.

The methodology used by CCME to conduct this review will follow the protocols developed by the Centers for Medicare and Medicaid Services (CMS) for external quality review of Medicaid Managed Care Organizations. As required by these protocols, the review will include both a desk review (at CCME), onsite visit and will address all contractually required services as well as follow up of any areas of weakness identified during the previous review. The CCME EQR team plans to conduct the onsite visit on **December 15th and 16th.**

In preparation for the desk review, the items on the enclosed desk materials list should be provided to CCME no later than **November 7, 2016.**

Submission of all the desk materials will be different than in the past. This year we have a new secure file transfer website for uploading desk materials electronically to CCME. The file transfer site can be found at:

https://eqro.thecarolinascenter.org

Upon registering with a username and password, you will receive an email with a link to confirm the creation of your account. After you have confirmed the account, CCME will be notified and will send an automated email once the security access has been set up. Please bear in mind that while you will be able to log in to the website after the confirmation of your account, you will see a message indicating that your registration is pending, until CCME grants you the appropriate security clearance. I have included written instructions on how to use the file transfer site and would be happy to schedule an education session (via webinar) on how to utilize the file transfer site if needed. Ensuring successful upload of desk materials is our priority and we value the opportunity to provide support.

An opportunity for a conference call with your staff, to describe the review process and answer any questions prior to the onsite visit, is being offered as well. Please contact me directly at 803-212-7582 if you would like to schedule time for either of these conversational opportunities.

Thank you and we look forward to working with you.

Sincerely,

Sandi Owens, LPN
Manager, External Quality Review

Enclosure
cc: SCDHHS

External Quality Review 2016

MATERIALS REQUESTED FOR DESK REVIEW

1. Copies of all current policies and procedures, as well as a complete index which includes policy name, number and department owner. The date of the addition/review/revision should be identifiable on each policy.

2. Organizational chart of all staff members including names of individuals in each position, and any current vacancies.

3. Current membership demographics including total enrollment and distribution by age ranges, sex, and county of residence.

4. Documentation of all service planning and provider network planning activities (e.g., geographic assessments, provider network assessments, enrollee demographic studies, population needs assessments) that support the adequacy of the provider base. Please include the maximum allowed and the current member-to-PCP ratios and member-to-specialist ratios.

5. A complete list of network providers for the Healthy Connections Choices (HCC) members. The list should be submitted as an excel spreadsheet and include the practitioner's name, title (MD, NP, PA etc.), specialty, practice name, address, phone number, counties served, if the provider is accepting new patients, and any age restrictions. Specialty codes and county codes may be used however please provide an explanation of the codes used by your organization. Please note this information will be used to conduct our telephone access study.

6. The total number of unique specialty providers as well as the total number of unique primary care providers currently in the network.

7. A current provider list/directory as supplied to members.

8. A copy of the current Compliance plan.

9. A description of the Credentialing, Quality Improvement, Medical/Utilization Management, Disease/Case Management, and Pharmacy Programs.

10. The Quality Improvement work plans for 2015, and 2016.

11. The most recent reports summarizing the effectiveness of the Quality Improvement, Medical/Utilization Management, and Disease/Case Management Programs.

12. Documentation of all Performance Improvement Projects (PIPs) completed or planned since the previous Annual Review, and any interim information available for those projects currently in progress. This documentation should include information from the project that explains and documents all aspects of the project cycle (i.e. analytic plans, reasons for choosing the topic, measurement definitions, interventions planned or implemented, calculated results, barriers to improvement, results, etc…).

13. Minutes of all committee meetings in the past year reviewing or taking action on SC Medicaid-related activities. All relevant attachments (e.g., reports presented, materials reviewed) should be included. If attachments are provided as part of another portion of this request, a cross-reference is satisfactory, rather than sending duplicate materials.

14. Membership lists and a committee matrix for all committees including the professional specialty of any non-staff members. Please indicate which members are voting members. Please include committee charters if available.

15. Any data collected for the purposes of monitoring the utilization (over and under) of health care services.

16. Copies of the most recent physician profiling activities conducted to measure contracted provider performance.

17. Results of the most recent medical office site reviews, medical record reviews and a copy of the tools used to complete these reviews.

18. A complete list of all members enrolled in the case management program from April 2016 through September 2016. Please include open and closed case management files, the member's name, Medicaid ID number, and condition or diagnosis which triggered the need for case management.

19. A copy of staff handbooks/training manuals, orientation and educational materials and scripts used by Member Services Representatives and/or Call Center personnel.

20. A copy of the member handbook and any statement of the member bill of rights and responsibilities if not included in the handbook.

21. A report of findings from the most recent member and provider satisfaction survey, a copy of the tool and methodology used. If the survey was performed by a subcontractor, please include a copy of the contract or other documentation of the requested scope of work.

22. A copy of any member and provider newsletters, educational materials and/or other mailings.

23. A copy of the Grievance, Complaint and Appeal logs for the months of September 2015 through September 2016.

24. Copies of all letter templates for documenting approvals, denials, appeals, grievances and acknowledgements.

25. Service availability and accessibility standards and expectations, and reports of any assessments made of provider and/or internal MCO compliance with these standards.

26. Preventive health practice guidelines recommended by the MCO for use by practitioners, including references used in their development, when they were last updated, how they are disseminated and how consistency with other MCO services and covered benefits is assessed.

27. Clinical practice guidelines for disease and chronic illness management recommended by the MCO for use by practitioners, including references used in their development, when they were last updated, how they are disseminated and how consistency with other MCO services and covered benefits is assessed.

28. A list of physicians currently available for utilization consultation/review and their specialty.

29. A copy of the provider handbook or manual.

30. A sample provider contract.

31. Documentation supporting requirements included in the Information Systems Capabilities Assessment for Managed Care Organizations (ISCAs). Please provide the following:
    a. A completed ISCA. *(Not a summarized ISCA or a document that contains ISCA-like information, but the ISCA itself.)*
    b. A network diagram showing (at a minimum) the relevant components in the information gathering, storage, and analysis processes. *(We are interested in the processing of claims and data in South Carolina, so if the health plan in South Carolina is part of a larger organization, the emphasis or focus should be on the network resources that are used in handling South Carolina data.)*
    c. A flow diagram or textual description of how data moves through the system. *(Please see the comment on b. above.)*
    d. A copy of the IT Disaster Recovery Plan or Business Continuity Plan.
    e. A copy of the most recent disaster recovery or business continuity plan test results.
    f. An organizational chart for the IT/IS department and a corporate organizational chart that shows the location of the IT organization within the corporation.
    g. A copy of the most recent data security audit, if completed.
    h. A copy of the policies or program description that address the information systems security and access management. Please also include polices with respect to email and PHI.
    i. A copy of the Information Security Plan & Security Risk Assessment.

32. A listing of all delegated activities, the name of the subcontractor(s), methods for oversight of the delegated activities by the MCO, and any reports of activities submitted by the subcontractor to the MCO.

33. Sample contract used for delegated entities. Specific written agreements with subcontractors may be requested at the onsite review at CCME's discretion.

34. Results of the most recent monitoring activities for all delegated activities. Include a full description of the procedure and/or methodology used and a copy of any tools used.
35. All HEDIS data and other performance and quality measures collected or planned. Required data and information include the following:
    a. data collection methodology used (e.g., administrative data, including sources; medical record review, including how records were identified and how the sample was chosen; hybrid methodology, including data sources and how the sample was chosen; or survey, including a copy of the tool, how the sample was chosen and how the data was input), including a full description of the procedures;

b. reporting frequency and format;
c. specifications for all components used to identify the eligible population (e.g., member ID, age, sex, continuous enrollment calculation, clinical ICD-9/CPT-4 codes, member months/years calculation, other specified parameters);
d. programming specifications that include data sources such as files/databases and fields with definitions, programming logic and computer source codes;
e. denominator calculations methodology, including:
    1) data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy files, enrollment files, etc.);
    2) specifications for all components used to identify the population for the denominator;
f. numerator calculations methodology, including:
    1) data sources used to calculate the numerator (e.g., claims files, medical records, provider files, pharmacy files, enrollment files, etc.);
    2) specifications for all components used to identify the population for the numerator;
g. calculated and reported rates.

36. Provide electronic copies of the following files:
    a. Credentialing files (including signed Ownership Disclosure Forms) for:
        i. Ten PCP's (Include two NP's acting as PCP's, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two network hospitals; and
        v. One file for each additional type of facility in the network.
    b. Recredentialing (including signed Ownership Disclosure Forms) files for:
        i. Ten PCP's (Include two NP's acting as PCP's, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two network hospitals; and
        v. One file for each additional type of facility in the network.
    c. Twenty medical necessity denial files made in the months of September 2015 through September 2016. Include any medical information and physician review documentations used in making the denial determination. Please include two behavioral health files and two acute inpatient rehabilitation files.
    d. Twenty-five utilization approval files (acute care and behavioral health) made in the months of September 2015 through September 2016, including any medical information and approval criteria used in the decision. Please include prior authorizations for surgery and/or hospital admissions, concurrent stay, and retrospective review of admissions and of emergency care.

    Note: Appeals, Grievances, and Care Coordination/Case Management files will be selected from the logs received with the desk materials. A request will then be sent to the plan to send electronic copies of the files to CCME.

These materials:

- **should be organized and uploaded to the secure CCME EQR File Transfer site at https://eqro.thecarolinascenter.org**
- **and submitted in the categories listed.**

B. Attachment 2: Materials Requested for Onsite Review

External Quality Review 2016

MATERIALS REQUESTED FOR ONSITE REVIEW

1. Copies of all committee minutes for committees that have met since the desk materials were copied.
2. Provide copies of the pre-delegation audit conducted on 4/11/16 for the delegated entity, Regional Health. The information was not received in the desk materials.
3. The following policies which were referenced in other policies and procedures:
   - C13RIM.001
   - C13RIM.002
   - C2ER-015
   - C13CP-003

4. Provide copies of the provider office site visits for primary care physician credentialing files provided in the desk materials.
5. For recredentialing file, Toriah Caldwell, APRN: the application stated “yes” to providing laboratory services, but a copy of the CLIA was not received in the file. Please provide the CLIA.
6. The following nurse practitioner recredentialing files included information regarding the supervision physicians but did not include a copy of the written protocols. Please provide.
   a. Toriah Caldwell, APRN
   b. Michele Lively, APRN

C. Attachment 3: EQR Validation Worksheets

- Performance Measure Validation
- Performance Improvement Project Validation
  - IMPROVING HEMOGLOBIN A1C TESTING
  - CHILD HEALTHCARE- PARENT/CAREGIVER SATISFACTION
- Member Satisfaction Survey Validation – CAHPS Adult
- Member Satisfaction Survey Validation – CAHPS Child

CCME EQR PM Validation Worksheet

Plan Name:	**WELLCARE**
Name of PM:	**ALL HEDIS MEASURES**
Reporting Year:	**2015**
Review Performed:	**12/2016**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
NCQA Volume 2: HEDIS® Technical Specifications for 2016

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1. Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**MET**	Plan uses NCQA Certified software Inovalon. This was verified and meets all review requirements.

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1. Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**MET**	Plan uses NCQA Certified software Inovalon. This was verified and meets all review requirements.
D2. Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Plan uses NCQA Certified software Inovalon. This was verified and meets all review requirements.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1. Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**MET**	Plan uses NCQA Certified software Inovalon. This was verified and meets all review requirements.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N2. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Plan uses NCQA Certified software Inovalon. This was verified and meets all review requirements.
N3. Numerator– Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**MET**	Plan contracts with Outcomes Health Information Solutions™, An Altegra Health Company, to conduct medical records abstractions.
N4. Numerator– Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**MET**	Plan uses NCQA Certified software Inovalon. This was verified and meets all review requirements.
N5. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**MET**	Plan uses NCQA Certified software Inovalon. This was verified and meets all review requirements.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1. Sampling	Sample was unbiased.	**MET**	Plan uses NCQA Certified software Inovalon. This was verified and meets all review requirements.
S2. Sampling	Sample treated all measures independently.	**MET**	Plan uses NCQA Certified software Inovalon. This was verified and meets all review requirements.
S3. Sampling	Sample size and replacement methodologies met specifications.	**MET**	Plan uses NCQA Certified software Inovalon. This was verified and meets all review requirements.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting	Was the measure reported accurately?	**MET**	Plan uses NCQA Certified software Inovalon. This was verified and meets all review requirements.
R2. Reporting	Was the measure reported according to State specifications?	**NA**	NA

VALIDATION SUMMARY			
Element	**Standard Weight**	**Validation Result**	**Score**
G1	10	MET	10
D1	10	MET	10
D2	5	MET	5
N1	10	MET	10
N2	5	MET	5
N3	5	MET	5
N4	5	MET	5
N5	5	MET	5
S1	5	MET	5
S2	5	MET	5
S3	5	MET	5
R1	10	MET	10
R2	0	NA	NA

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	**80**
Measure Weight Score	**80**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with State specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.*
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.*
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

CCME EQR PIP Validation Worksheet

Plan Name:	**WELLCARE**
Name of PIP:	IMPROVING HEMOGLOBIN A1C TESTING
Reporting Year:	2015
Review Performed:	2016

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Analysis of data regarding enrollee care is documented.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	This addresses a key aspect of enrollee care.
1.3 Did the MCO's/PIHP's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	All relevant populations are included.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**MET**	Study question was stated in document on page 3.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measures are clearly defined.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicator measures changes in health status and processes of care.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**MET**	A clear definition of enrollees to whom the study question is relevant is documented.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**MET**	Data collection approach captured all enrollees to whom the study measure applied.
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling was not used.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or*	**NA**	Sampling was not used.

Component / Standard (Total Points)	Score	Comments
census used:		
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling was not used.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected is documented.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Data source is identified as Administrative Data.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Programmed pull from claims/encounter files of all eligible members.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	There is consistent data collection using program pulled data.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	The data analysis plan is specified as once per year.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**NOT MET**	Study leader is listed in documentation; however, staff used to collect/pull data and their qualifications is not listed. *Recommendation: Include staff and qualifications in Section D2 of documentation.*
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Several interventions are implemented.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Analysis of findings is performed according to the data analysis plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are presented clearly.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**NA**	Only baseline measurement was conducted.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis included interpretation of success and continued action plans.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**NA**	Measurement has not been repeated.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NA**	Measurement has not been repeated.
9.3 Does the reported improvement in performance have "face"	**NA**	Measurement has not been

Component / Standard (Total Points)	Score	Comments
validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**		repeated.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Measurement has not been repeated.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Measurement has not been repeated.

ACTIVITY 2: VERIFYING STUDY FINDINGS

Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? **(20)**	**NA**	**NA**

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

Steps	Possible Score	Score
Step 1		
1.1	5	5
1.2	1	1
1.3	1	1
Step 2		
2.1	10	10
Step 3		
3.1	10	10
3.2	1	1
Step 4		
4.1	5	5
4.2	1	1
Step 5		
5.1	NA	NA
5.2	NA	NA
5.3	NA	NA
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1

Steps	Possible Score	Score
Step 6		
6.4	5	5
6.5	1	1
6.6	5	0
Step 7		
7.1	10	10
Step 8		
8.1	5	5
8.2	10	10
8.3	NA	NA
8.4	1	1
Step 9		
9.1	NA	NA
9.2	NA	NA
9.3	NA	NA
9.4	NA	NA
Step 10		
10.1	NA	NA
Verify		
TOTAL		

Project Score	73
Project Possible Score	78
Validation Findings	94%

AUDIT DESIGNATION
HIGH CONFIDENCE

AUDIT DESIGNATION POSSIBILITIES	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. *Validation findings must be 90%–100%.*
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the project. *Validation findings must be 70%–89%.*
Low Confidence in Reported Results	Plan deviated from or failed to follow their documented procedure in a way that data was misused or misreported, thus introducing major bias in results reported. *Validation findings between 60%–69% are classified here.*
Reported Results NOT Credible	Major errors that put the results of the entire project in question. *Validation findings below 60% are classified here.*

CCME EQR PIP Validation Worksheet

Plan Name:	**WELLCARE**
Name of PIP:	CHILD HEALTHCARE- PARENT/CAREGIVER SATISFACTION
Reporting Year:	2015
Review Performed:	2016

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Analysis of data regarding enrollee services is documented.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	This addresses a key aspect of enrollee services.
1.3 Did the MCO's/PIHP's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	All relevant populations are included.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**MET**	Study question is stated in document on page 3.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measures are clearly defined.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicator measures changes in enrollee satisfaction.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**MET**	A clear definition of enrollees to whom the study question is relevant is documented.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**MET**	Data collection approach captures all enrollees to whom the study measure applied.
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**MET**	Sampling is conducted according to HEDIS specifications.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or*	**MET**	Sampling is conducted according to HEDIS specifications.

Component / Standard (Total Points)	Score	Comments
census used:		
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**MET**	Sampling is conducted according to HEDIS and contains a sufficient number of enrollees.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected is documented.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Data source is identified as Survey Data.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Data is collected using mixed methods as described in HEDIS.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**NOT MET**	It is documented that the HEDIS 2014 specifications were followed for the baseline measurement year. Which HEDIS specifications were used for the 2015 and 2016 measurement years is not clearly documented. *Recommendation: Clearly document the year and volume of HEDIS specifications used for each remeasurement period in the documentation.*
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	The data analysis plan is specified as once per year.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	SPH Analytics is utilized to collect and analyze data.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Several interventions are implemented.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Analysis of findings is performed according to the data analysis plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are presented clearly.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Analysis identifies initial and repeat measurements.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis includes interpretation of success and continued action plans.

Component / Standard (Total Points)	Score	Comments
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**NA**	It is unclear if HEDIS technical specifications from 2014 are used for all measures or if the HEDIS specifications for each year are utilized.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	There is an initial increase of 6% and then a slight decrease. The most recent rate of 65.1% is above the Benchmark set at the onset of the study, which is 63.4%.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	Improvement appears to be result of several interventions.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**MET**	Chi square tests demonstrate a statistically significant increase from baseline (2014) to the current rate (2016) using an alpha level of .05.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge; only two repeat measurements.

ACTIVITY 2: VERIFYING STUDY FINDINGS

Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? **(20)**	**NA**	**NA**

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

Steps	Possible Score	Score
Step 1		
1.1	5	5
1.2	1	1
1.3	1	1
Step 2		
2.1	10	10
Step 3		
3.1	10	10
3.2	1	1
Step 4		
4.1	5	5
4.2	1	1
Step 5		
5.1	5	5
5.2	10	10
5.3	5	5
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1

Steps	Possible Score	Score
Step 6		
6.4	5	0
6.5	1	1
6.6	5	5
Step 7		
7.1	10	10
Step 8		
8.1	5	5
8.2	10	10
8.3	1	1
8.4	1	1
Step 9		
9.1	NA	NA
9.2	1	1
9.3	5	5
9.4	1	1
Step 10		
10.1	NA	NA
Verify		
TOTAL		

Project Score	101
Project Possible Score	106
Validation Findings	95%

AUDIT DESIGNATION
HIGH CONFIDENCE

AUDIT DESIGNATION POSSIBILITIES	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. *Validation findings must be 90%–100%.*
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the project. *Validation findings must be 70%–89%.*
Low Confidence in Reported Results	Plan deviated from or failed to follow their documented procedure in a way that data was misused or misreported, thus introducing major bias in results reported. *Validation findings between 60%–69% are classified here.*
Reported Results NOT Credible	Major errors that put the results of the entire project in question. *Validation findings below 60% are classified here.*

CCME EQR Survey Validation Worksheet

Plan Name	**WELLCARE**
Survey Validated	**CAHPS ADULT**
Validation Period	2016
Review Performed	12/2016

Review Instructions

Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted, since the lack of information is relevant to the assessment of that activity. (V2 updated based on September 2012 version of EQR protocol 5)

ACTIVITY 1: REVIEW SURVEY PURPOSE(S), OBJECTIVE(S) AND INTENDED USE

Survey Element		Element Met / Not Met	Comments And Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	The statement of purpose is documented. Documentation: *SPH Analytics 2016 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey*
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	The study objectives are clearly documented. Documentation: *SPH Analytics 2016 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey*
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Intended audience is identified and documented. Documentation: *SPH Analytics 2016 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey*

ACTIVITY 2: ASSESS THE RELIABILITY AND VALIDITY OF THE SURVEY INSTRUMENT

Survey Element		Element Met / Not Met	Comments And Documentation
2.1	Assess whether the survey instrument was tested and found reliable (i.e. use of industry experts and/or focus groups).	**MET**	Reliability of the survey is documented. Documentation: *SPH Analytics 2016 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey (page i)*
2.2	Assess whether the survey instrument was tested and found valid. (Correlation coefficients equal to or better than 0.70 for a test/retest comparison).	**MET**	Validity of the survey and responses are documented. Documentation: *SPH Analytics 2016 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey (page i)*

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments And Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Documentation: *SPH Analytics 2016 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey*
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	**MET**	Documentation: *SPH Analytics 2016 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey*
3.3	Review that the sampling strategy (simple random, stratified random, nonprobability) was appropriate.	**MET**	The sampling strategy is appropriate. Documentation: *SPH Analytics 2016 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey*
3.4	Review whether the sample size is sufficient for the intended use of the survey. Include: Acceptable margin of error Level of certainty required	**MET**	The required sample size is 1,350 according to NCQA. WellCare has a sample size of 1,566. Documentation: *SPH Analytics 2016 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey*
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Appropriate procedures are used to select the sample. Documentation: *SPH Analytics 2016 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey*

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments And Documentation
4.1	Review the specifications for calculating raw and adjusted response rates to make sure they are clear and appropriate.	**MET**	Specifications for calculating raw and adjusted response rates were aligned with NCQA protocol, and are clear and appropriate. Documentation: *SPH Analytics 2016 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey*
4.2	Assess the response rate, potential sources of nonresponse and bias, and implications of the response rate for the generalize ability of survey findings.	**NOT MET**	The overall response rate was 25.0%. The target response rate according to NCQA is 40.0%. Documentation: *SPH Analytics 2016 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey* *Recommendation: Implement strategies to increase response rates.*

ACTIVITY 5: REVIEW THE SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments And Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of survey data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	A quality assurance plan is in place. Documentation: *SPH Analytics 2016 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey*
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation follows the planned approach. Documentation: *SPH Analytics 2016 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey*
5.3	Were confidentiality procedures followed?	**MET**	Confidentiality procedures are followed. Documentation: *SPH Analytics 2016 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey*

ACTIVITY 6: REVIEW SURVEY DATA ANALYSIS AND FINDINGS / CONCLUSIONS

Survey Element		Element Met / Not Met	Comments And Documentation
6.1	Was the survey data analyzed?	**MET**	Data is analyzed. Documentation: *SPH Analytics 2016 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey*
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate statistical tests are conducted. Documentation: *SPH Analytics 2016 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey*
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Survey conclusions are supported by findings. Documentation: *SPH Analytics 2016 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey*

ACTIVITY 7: DOCUMENT THE EVALUATION OF SURVEY

Results Elements		Validation Comments And Conclusions
7.1	Identify the technical strengths of the survey and its documentation.	-The use of a CAHPS certified vendor allows for a standardized and audited approach to the implementation and analysis of the surveys. - SPH Analytics, as a vendor, provides a full report of process and results that meets the necessary requirements and expectations of a survey report.
7.2	Identify the technical weaknesses of the survey and its documentation.	No technical weaknesses are noted in the review.
7.3	Do the survey findings have any limitations or problems with generalization of the results?	The overall response rate was 25.0%. The target response rate according to NCQA is 40.0%, thus, caution should be utilized when generalizing the results to the population.
7.4	What conclusions are drawn from the survey data?	The plan scored below the 25th percentile on Getting Care Quickly, Rating of Health Care, and Rating of Health Plan composites. The plan is in the 90th percentile for Rating of Specialist and How Well Doctors communicate composites. Documentation: *SPH Analytics 2016 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey*
7.5	Assessment of access, quality, and/or timeliness of healthcare furnished to beneficiaries by the MCO (if not done as part of the original survey report by the plan).	CAHPS Results are provided to members in a brief summary in the English version of the newsletter. Documentation: *sc_caid_Member_Newsletter Eng Issue Q3_2016 p.4*
7.6	Comparative information about all MCOs (as appropriate).	Comparative information is provided and documented. Documentation: *SPH Analytics 2016 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey*

CCME EQR Survey Validation Worksheet

Plan Name	**WELLCARE**
Survey Validated	**CAHPS CHILD**
Validation Period	2016
Review Performed	12/2016

Review Instructions

Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted, since the lack of information is relevant to the assessment of that activity. (V2 updated based on September 2012 version of EQR protocol 5)

ACTIVITY 1: REVIEW SURVEY PURPOSE(S), OBJECTIVE(S) AND INTENDED USE

Survey Element		Element Met / Not Met	Comments And Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	The statement of purpose is documented. Documentation: *SPH Analytics 2016 MCS Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey*
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	The study objectives are clearly documented. Documentation: *SPH Analytics 2016 MCS Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey*
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Intended audience is identified and documented. Documentation: *SPH Analytics 2016 MCS Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey*

ACTIVITY 2: ASSESS THE RELIABILITY AND VALIDITY OF THE SURVEY INSTRUMENT

Survey Element		Element Met / Not Met	Comments And Documentation
2.1	Assess whether the survey instrument was tested and found reliable (i.e. use of industry experts and/or focus groups).	**MET**	Reliability of the survey is documented. Documentation: *SPH Analytics 2016 MCS Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey*
2.2	Assess whether the survey instrument was tested and found valid. (Correlation coefficients equal to or better than 0.70 for a test/retest comparison).	**MET**	Validity of the survey and responses are documented. Documentation: *SPH Analytics 2016 MCS Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey*

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments And Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Documentation: *SPH Analytics 2016 MCS Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey*
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	**MET**	Documentation: *SPH Analytics 2016 MCS Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey*
3.3	Review that the sampling strategy (simple random, stratified random, nonprobability) was appropriate.	**MET**	The sampling strategy is appropriate. Documentation: *SPH Analytics 2016 MCS Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey*
3.4	Review whether the sample size is sufficient for the intended use of the survey. Include: Acceptable margin of error Level of certainty required	**MET**	The required sample size is 1,350 according to NCQA. WellCare has a sample size of 1,898. Documentation: *SPH Analytics 2016 MCS Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey*
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Appropriate procedures are used to select the sample. Documentation: *SPH Analytics 2016 MCS Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey*

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments And Documentation
4.1	Review the specifications for calculating raw and adjusted response rates to make sure they are clear and appropriate.	**MET**	Specifications for calculating raw and adjusted response rates are aligned with NCQA protocol, and are clear and appropriate. Documentation: *SPH Analytics 2016 MCS Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey*
4.2	Assess the response rate, potential sources of nonresponse and bias, and implications of the response rate for the generalize ability of survey findings.	**NOT MET**	The overall response rate is 18.6%. The target response rate according to NCQA is 40.0%. Documentation: *SPH Analytics 2016 MCS Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey* *Recommendation: Implement strategies to increase response rates.*

ACTIVITY 5: REVIEW THE SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments And Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of survey data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	A quality assurance plan is in place. Documentation: *SPH Analytics 2016 MCS Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey*
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation follows the planned approach. Documentation: *SPH Analytics 2016 MCS Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey*
5.3	Were confidentiality procedures followed?	**MET**	Confidentiality procedures are followed. Documentation: *SPH Analytics 2016 MCS Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey*

ACTIVITY 6: REVIEW SURVEY DATA ANALYSIS AND FINDINGS / CONCLUSIONS

Survey Element		Element Met / Not Met	Comments And Documentation
6.1	Was the survey data analyzed?	**MET**	Data is analyzed. Documentation: *SPH Analytics 2016 MCS Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey*
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate statistical tests are conducted. Documentation: *SPH Analytics 2016 MCS Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey*
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Survey conclusions are supported by findings. Documentation: *SPH Analytics 2016 MCS Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey*

ACTIVITY 7: DOCUMENT THE EVALUATION OF SURVEY

	Results Elements	Validation Comments And Conclusions
7.1	Identify the technical strengths of the survey and its documentation.	-The use of a CAHPS certified vendor allows for a standardized and audited approach to the implementation and analysis of the surveys. - SPH Analytics, as a vendor, provides a full report of process and results that meets the necessary requirements and expectations of a survey report.
7.2	Identify the technical weaknesses of the survey and its documentation.	No technical weaknesses are noted in the review.
7.3	Do the survey findings have any limitations or problems with generalization of the results?	The overall response rate is 18.6%. The target response rate according to NCQA is 40.0%, thus, caution should be utilized when generalizing the results to the population.
7.4	What conclusions are drawn from the survey data?	The plan scored just above the 25th percentile on rating of Health Plan. However, the composite scores of Getting Needed Care, Getting Care Quickly, and How Well Doctors Communicate, are all ranked at the 90th percentile; Customer Service scores are at the 75th percentile. Documentation: *SPH Analytics 2016 MCS Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey*
7.5	Assessment of access, quality, and/or timeliness of healthcare furnished to beneficiaries by the MCO (if not done as part of the original survey report by the plan).	CAHPS Results are provided to members in a brief summary in the English version of the newsletter for the following composites: Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Rating of WellCare (Health Plan). Documentation: *sc_caid_Member_Newsletter Eng Issue Q3_2016 p.4*
7.6	Comparative information about all MCOs (as appropriate).	Comparative information is provided and documented. Documentation: *SPH Analytics 2016 MCS Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey*

D. Attachment 4: Tabular Spreadsheet

CCME MCO Data Collection Tool

Plan Name:	**WellCare of South Carolina**
Review Performed:	2016

I. ADMINISTRATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I. ADMINISTRATION						
I A. General Approach to Policies and Procedures						
1. The MCO has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly.	X					WellCare of South Carolina (WellCare) has a comprehensive set of policies and procedures that are organized in a consistent manner and reviewed annually. Policies are tracked electronically in Compliance 360. Employees receive monthly email notification regarding new or modified policies and procedures.
I B. Organizational Chart / Staffing						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO's resources are sufficient to ensure that all health care products and services required by the State of South Carolina are provided to members. At a minimum, this includes designated staff performing in the following roles:						The organizational chart confirms WellCare has sufficient staff located in South Carolina to meet the needs of their members. WellCare of South Carolina receives support services from their parent company, WellCare Health Plans, Inc. located in Tampa, Florida.
1.1 *Administrator (CEO, COO, Executive Director);	X					Kathy Warner is plan president for WellCare and oversees the day-to-day business activities. Christy Lassiter is senior director of strategic operations.
1.2 Chief Financial Officer;	X					Janice Fuller serves as the local finance manager.
1.3 * Contract Account Manager;	X					Paul Schaefer is director of state regulatory affairs and contract manager.
1.4 Information Systems personnel;						IT functions are managed out of the corporate offices in Tampa, Florida. Nicholas Barfield is the regional system support specialist who supports IT functions locally.
1.4.1 Claims and Encounter Manager/Administrator,	X					WellCare has a centralized claims and an encounter data manager located in Tampa, Florida.
1.4.2 Network Management Claims/Encounter Processing Staff,	X					Julia Pinckney is the director of network management.
1.5 Utilization Management (Coordinator, Manager, Director);	X					Michael Radu is the senior vice president of clinical operations and business development. Utilization functions are performed in regional offices and managed by WellCare corporate.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.5.1 Pharmacy Director,	X					Joseph Geter is a SC licensed pharmacist and serves as pharmacy director for WellCare.
1.5.2 Behavioral Health Coordinator,	X					Kimberly McElroy serves locally as the director of product operations for Behavioral Health.
1.5.3 Utilization Review Staff,	X					Behavioral Health utilization staff is identified on the organizational chart submitted during the onsite visit.
1.5.4 *Case Management Staff,	X					Chryste Middleton is the senior manager of field services and reports to the Senior Medical Director, Dr. Robert London. Care Transitions field staff assist members in transitions between levels of care to make sure members have what they need, get required services to maintain successful transitions, and reduce risk of re-hospitalization.
1.6 *Quality Improvement (Coordinator, Manager, Director);	X					Bobbi Crimm is senior director of quality improvement. A search is underway to fill the position for director of quality improvement.
1.6.1 Quality Assessment and Performance Improvement Staff,	X					The quality department includes QI specialists, project managers, coordinators, and clinical HEDIS practice advisors.
1.7 *Provider Services Manager;	X					Darrick Williams is senior manager of provider relations.
1.7.1 *Provider Services Staff,	X					
1.8 *Member Services Manager;	X					Anton Brown serves as director of community relations/member services manager.
1.8.1 Member Services Staff,	X					Member services call center staff is located in South Carolina and serves WellCare of South

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Carolina and other WellCare markets.
1.9 *Medical Director;	X					Dr. Robert London is the senior medical director, located in South Carolina and board certified in OB/GYN. The market medical directors work in collaboration with the Corporate Utilization Management (UM) staff by providing leadership overseeing the operational implementation of the Utilization Management Program. Other responsibilities are detailed in the *UM Program Description* and job description. Dr. London chairs the Credentialing and Utilization Management Advisory Committees and serves on the Quality Improvement and the Medical Policy Committee. Dr. London attended nearly all the committee meetings as noted in the minutes. Dr. London is integral to the development of a telemedicine program for WellCare. The corporate medical directors complete clinical reviews when medical necessity is not met and have the authority to make all medical necessity denial determinations.
1.10 *Compliance Officer;	X					Mark Ruise is director of market compliance liaison and reports directly to the plan president and to Corporate Compliance.
1.11 * Interagency Liaison;	X					Taffney Hooks is manager of field regulatory affairs and interagency liaison.
1.12 Legal Staff.	X					
2. Operational relationships of MCO staff are clearly delineated.	X					The local reporting structure is detailed in the SC Organizational chart. WellCare provided additional charts that included UM and Appeals,

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Behavioral Health, and Compliance.
3. Operational responsibilities and appropriate minimum education and training requirements are identified for all MCO staff positions.	X					Per onsite discussion, job descriptions include responsibilities, educational requirements, and experience/training. All employees are monitored monthly to ensure they are not prohibited from participating in Medicaid or other government programs.
I C. Management Information Systems						
1. The MCO processes provider claims in an accurate and timely fashion.	X					WellCare surpasses South Carolina's MCO contract requirements for processing claims: 99.72% of WellCare's claims are processed within 30 days, and 99.97% are processed within 90 days. WellCare tracks claim performance and conducts daily claim audits to validate claims processing meets the *SCDHHS Contract* requirements.
2. The MCO is capable of accepting and generating HIPAA compliant electronic transactions.	X					WellCare has contracts with a number of partners to conduct electronic claims transactions. WellCare partners provide services accepting and fulfilling claims using HIPAA compliant EDI transactions, scanning paper claims into electronic formats, and providing web-based direct entry capabilities.
3. The MCO tracks enrollment and demographic data and links it to the provider base.	X					WellCare loads eligibility files into an enrollment and eligibility system within 24 hours of receipt. If there are any errors processing eligibility files (834 files), enrollment analysts perform manual reviews and generate a report provided to SCDHHS. Within WellCare's enrollment and eligibility system, unique subscriber

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						identification numbers are used to uniquely identify Medicaid enrollees. Finally, WellCare and its partners use multi-tiered processes to identify, log, correct, and report duplicate records.
4. The MCO management information system is sufficient to support data reporting to the State and internally for MCO quality improvement and utilization monitoring activities.	X					The ISCA materials provided indicate that WellCare's IT systems are capable of meeting the performance requirements of the *SCDHHS Contract*. In addition to adequate monitoring and storage capabilities, WellCare notes that its enrollment and eligibility system is capable of processing more than 18,000 member and provider transactions daily.
5. The MCO has policies, procedures and/or processes in place for addressing data security as required by the contract.		X				WellCare had a security audit performed by an external third party between June 23, 2016 and July 6, 2016. This audit revealed a number of areas needing improvement. WellCare did not provide documentation indicating corrective measures are planned. *Quality Improvement Plan: Document the corrective action measures planned or taken to correct and improve the issues identified in the security audit.*
6. The MCO has policies, procedures and/or processes in place for addressing system and information security and access management.	X					WellCare's ISCA documentation demonstrates that it has implemented the IT security policies, procedures, and processes needed to fulfill the requirements of the *SCDHHS Contract*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
7. The MCO has a disaster recovery and/or business continuity plan, such plan has been tested, and the testing has been documented.	X					WellCare has a thorough disaster recovery plan that addresses when a disaster should be declared, the resources needed to recover, and steps needed to conduct recovery operations. WellCare tested its disaster recovery procedures in the first quarter of 2016 and the test results surpassed all of WellCare's recovery requirements.
I D. Compliance/Program Integrity						
1. The MCO has policies, procedures, and a Compliance Plan that are consistent with state and federal requirements to guard against fraud and abuse.	X					WellCare has a Corporate Compliance Plan with state specific appendix, multiple policies and procedures, a Code of Conduct and Business Ethics agreement that together define the processes used to implement all aspects of the Compliance Plan. A Compliance Plan Matrix details the *SCDHHS Contract* requirements and where they are found in the documentation. Hotlines for compliance reporting are found in the Compliance Plan, on WellCare's website, in the *Provider Manual* and *Member Handbook*. The Hotline provides anonymous reporting when desired. The *Provider Manual* includes that providers and their staff are required to complete fraud, waste, and abuse training annually. WellCare performs numerous fraud, waste, and abuse reviews and audits. These include claims reviews, data mining, pharmacy audits, and a variety of automated reviews designed to

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						prevent and detect suspected fraud and abuse.
2. The MCO has established a committee charged with oversight of the Compliance program, with clearly delineated responsibilities.	X					The Compliance Plan Format document states the Compliance Committee is comprised of senior leadership and chaired by the compliance officer and meets quarterly. Members include key market leaders from Quality, Health Services, Regulatory Affairs, Finance, Network Management, and the plan president.
I E. Confidentiality						
1. The MCO formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy.	X					The *Notice of Privacy Practices* is included in the *Member Handbook*. *Policy SC22 HIP.01.004-ST, Corporate Policy HIPAA,* states each associate is required to complete the HIPAA Training Program. This training is delivered within 30 days of the employee hire date and annually thereafter. An Introduction to Safeguarding PHI training brings awareness to the basic measures WellCare uses to protect member's PHI. This training is delivered within the first few days of an associate's start of employment date. It does not include a statement that states HIPAA training must be completed prior receiving access to PHI. *Recommendation: Include in Policy SC22 HIP.01.004-ST, Corporate Policy HIPAA, or other appropriate policy, that HIPAA training is*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						conducted prior to accessing any PHI.

II. PROVIDER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II. PROVIDER SERVICES						
II A. Credentialing and Recredentialing						
1. The MCO formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in manner consistent with contractual requirements.	X					The *Credentialing Program Description* provides a broad overview of the credentialing program. *Policy SC22 HS-CR-001* and *Procedure SC22 HS-CR-001-PR-001* detail SC credentialing and recredentialing guidelines for practitioners, and *Policy SC22 OP-CR-005* addresses assessment of organizational providers. Additional policies address various processes or guidelines related to the credentialing department.
2. Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be		X				The Credentialing Committee is chaired by Dr. Robert London, medical director, and the committee meets monthly. The list of voting committee members received in the desk

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
overridden by the MCO.						materials reflect the committee chair and three network providers with specialties in cardiology, hematology/oncology, and family medicine. However, onsite discussion with Dr. London confirmed that three additional network providers have been added to the committee; Dr. Mubarak and Dr. Jayagopalin were added in July 2016, and Dr. Jasper in November 2016. The list of Credentialing Committee members needs to be updated to reflect the current membership. A quorum is met with a majority of the committee membership in attendance. *Quality Improvement Plan: Update the list of Credentialing Committee members to reflect the current voting members of the committee.*
3. The credentialing process includes all elements required by the contract and by the MCO's internal policies.	X					The credentialing file review showed the files were organized and contained appropriate documentation.
3.1 Verification of information on the applicant, including:						
3.1.1 Current valid license to practice in each state where the practitioner will treat members;	X					
3.1.2 Valid DEA certificate and/or CDS Certificate;	X					
3.1.3 Professional education and training, or board certification if claimed by the applicant;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.4 Work history;	X					
3.1.5 Malpractice claims history;	X					
3.1.6 Formal application with attestation statement delineating any physical or mental health problem affecting ability to provide health care, any history of chemical dependency/ substance abuse, prior loss of license, prior felony convictions, loss or limitation of practice privileges or disciplinary action, the accuracy and completeness of the application;	X					
3.1.7 Query of the National Practitioner Data Bank (NPDB);	X					
3.1.8 No debarred, suspended, or excluded from Federal procurement activities: Query of System for Award Management (SAM);	X					
3.1.9 Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline); State Excluded Provider's Report;	X					
3.1.10 Query for Medicare and/or Medicaid sanctions (5 years); OIG List of Excluded Individuals and Entities (LEIE);	X					
3.1.11 In good standing at the hospitals designated by the provider as the primary admitting facility. (hospital privileges/coverage plan);	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.12 Clinical Laboratory Improvement Amendment (CLIA) Certificate (or certificate of waiver) for providers billing laboratory procedures;	X					
3.1.13 Ownership Disclosure form .	X					
3.2 Site assessment, including but not limited to adequacy of the waiting room and bathroom, handicapped accessibility, treatment room privacy, infection control practices, appointment availability, office waiting time, record keeping methods, and confidentiality measures.	X					
3.3 Receipt of all elements prior to the credentialing decision, with no element older than 180 days.	X					
4. The recredentialing process includes all elements required by the contract and by the MCO's internal policies.	X					The recredentialing file review showed the files were organized and contained appropriate documentation.
4.1 Recredentialing every three years;	X					
4.2 Verification of information on the applicant, including:						
4.2.1 Current valid license to practice in each state where the practitioner will treat members;	X					
4.2.2 Valid DEA certificate;	X					
4.2.3 Board certification if claimed by the applicant;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.4 Malpractice claims since the previous credentialing event;	X					
4.2.5 Practitioner attestation statement;	X					
4.2.6 Requery the National Practitioner Data Bank (NPDB);	X					
4.2.7 Requery of Service System for Award Management (SAM);	X					
4.2.8 Requery for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline); State Excluded Provider's Report;	X					
4.2.9 Requery for Medicare and/or Medicaid sanctions since the previous credentialing event; OIG List of Excluded Individuals and Entities (LEIE);	X					
4.2.10 In good standing at the hospitals designated by the provider as the primary admitting facility. (hospital privileges/coverage plan);	X					
4.2.11 Clinical Laboratory Improvement Amendment (CLIA) Certificate for providers billing laboratory procedures;	X					
4.2.12 Ownership Disclosure form.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.3 Site reassessment if the provider location has changed since the previous credentialing activity.	X					*Policy, SC22 HS-CR-027, SC Site Inspection Evaluation* (SIE), states that onsite visits will be conducted within 45 days of meeting the threshold for grievances. In addition to site visits for cumulative triggers, an SIE may be performed for an individual grievance or quality of care concern/adverse event if the severity of the issue is determined to warrant an onsite review per the South Carolina medical director or Credentialing Committee.
4.4 Review of practitioner profiling activities.	X					*Policy SC22 HS-CR-010, SC - Quality Review*, states that WellCare ensures that a provider's quality-monitoring and quality-review information is incorporated into the credentialing peer review process. The Credentialing Department submits a list of providers due for re-credentialing to the quality improvement analyst (QIA) quarterly. The QIA checks the database for confirmed quality issues; confirmed trends; grievances; and corrective provider education. If a quality issue is found, a quality profile is provided to Credentialing. CCME received evidence that quality is considered during recredentialing in the recredentialing files.
5. The MCO formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the MCO for serious quality of care or service issues.	X					*Policy SC22 HS-QI-015, SC-Quality of Care Issues,* defines the guidelines and procedures for identifying, investigating, tracking, trending, and reporting potential and/or actual quality of care (QOC) issues. Issues are tracked and trended by volume or occurrence and

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						submitted for review and incorporation into the Peer Review process. *Policy SC22 HS-CR-020, SC - Hearing and Appellate Review,* defines the process utilized when a practitioner does not meet the quality standards of care, conduct, participation, or service criteria. This can include issuing corrective action or termination. In the event the Plan finds it necessary to make an adverse participation determination against a practitioner relative to quality of care or conduct, the practitioner is offered a hearing and appeal process through a Hearing and Appellate Review Peer Review Panel. The Plan denotes how WellCare conducts all necessary reporting to appropriate authorities.
6. Organizational providers with which the MCO contracts are accredited and/or licensed by appropriate authorities.	X					*Policy SC22 HS-CR-009, SC - Assessment of Organizational Providers*, defines the process of initial and ongoing assessments of organizational providers. Credentialing and recredentialing files reflect appropriate documentation.
7. Monthly provider monitoring is conducted by the MCO to ensure providers are not prohibited from receiving Federal funds.	X					*Policy SC22 HS-CR-046* and *Procedure SC22 HS-CR-046-PR-001, SC Ongoing Monitoring of Providers*, define the process of monitoring providers on a monthly basis. The monitoring includes review of Medicaid Sanction Exclusions and Reinstatement reports; the List of Excluded Individuals and Entities; the System for Award Management; South Carolina Excluded Provider List; professional licensing sanctions; and

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						internal provider performance monitoring through the collection and review of grievances or adverse event information.
II B. Adequacy of the Provider Network						
1. The MCO maintains a network of providers that is sufficient to meet the health care needs of members and is consistent with contract requirements.						
1.1 Members have a primary care physician located within a 30-mile radius of their residence.	X					*Policy SC22 OP-NI-001, SC - GeoAccess Reporting*, defines the requirements for ensuring geographic access to healthcare services in accordance with the Medicaid contract. Primary care physicians are evaluated for the performance standard of one of each type of PCP (family/general practitioners, internal medicine, pediatricians) within a 30 mile radius of a member's home. OBGYNs acting as PCPs are also included. Evidence of GEOAccess reporting was received in the desk materials along with other reports that address the gap analysis. Results from *2015 QI Program Evaluation* show that 100% of members have access to a PCP within 30 miles.
1.2 Members have access to specialty consultation from a network provider located within reasonable traveling distance of their homes. If a network specialist is not available, the member may utilize an out-of-network specialist with no benefit penalty.		X				*Policy SC22 OP-NI-001, SC - GeoAccess Reporting*, states that members will have access to specialty consultation from a network provider located within a 50 mile radius of their homes. The policy references a table 2.11 and website links for the *SC Policy and Procedure Guide* for MCOs; both are incorrect

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						and need to be either removed or updated. The policy mentions a standard for specialists but does not mention standards for pharmacy, hospitals, or behavioral health. The policy does not address network access goals used to determine deficiencies. *Quality Improvement Plan: Update Policy SC22 OP-NI-001, SC - GeoAccess Reporting, to include more detail on the standards used for GEOAccess analysis and include goals used to determine network deficiencies.*
1.3 The sufficiency of the provider network in meeting membership demand is formally assessed at least bi-annually.	X					The geographic sufficiency of the network is evaluated on a biannual basis as defined in *Policy SC22 OP-NI-001, SC - GeoAccess Reporting*.
1.4 Providers are available who can serve members with special needs such as hearing or vision impairment, foreign language/cultural requirements, and complex medical needs.	X					*Policy SC22 SM-005, SC Cultural Competency*, defines the requirement that WellCare must have a cultural competency plan to ensure services and materials are provided in a culturally effective manner to all members, including those with limited English proficiency. The *2015 QI Program Evaluation* states the objective is to ensure members have access to a provider network that meets member cultural, linguistic, ethnic, and racial needs. WellCare monitors and responds to member grievances regarding cultural, linguistic, ethnic, and racial needs and annually assesses the needs of membership to ensure the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						availability of practitioners within the network. Results showed that 1% of the WellCare membership indicated speaking Spanish, while 5% of the provider network has Spanish speaking capabilities. Member materials are available in Spanish, and translation services are offered for members and providers. Providers are informed of the Cultural Competency program in the *Provider Manual* which includes a detailed explanation and states that providers must adhere to the program. Providers can also access training on WellCare's website.
1.5 The MCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand.	X					
2. The MCO maintains a provider directory that includes all requirements outlined in the contract.	X					*Policy SC22 OP-NI-003, SC- Provider Directory Production,* defines the information listed in provider directories that complies with contract requirements. *Policy SC22 OP-PC-021, SC Web-Based Provider Directory,* addresses information that is loaded to the web-based *Provider Directory*, which is updated nightly. A review of the web-based *Provider Directory* showed the language search option was hard to find with no instructions for the user. *Recommendation: Update the web-based Provider Directory to include the language search option in a more prominent area and*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						instructions for the user.
3. Practitioner Accessibility						
3.1 The MCO formulates and insures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.		X				*Policy SC22 OP-NI-002, SC Provider Appointment and After-Hours Coverage,* states that WellCare will monitor the timeliness of access to care within its provider networks via appointment accessibility and after-hours telephone surveys per requirements outlined by regulatory agencies, contractual requirements and/or accrediting bodies. The policy defines appointment access standards that comply with contract guidelines. The *Provider Manual* defines appointment access standards but page 102 does not contain the following standard for behavioral health that is listed in the policy, "non-life threatening emergency within 6 hours." CCME received the *2016 Appointment Availability & Accessibility* report conducted by The Myers Group in the desk materials. Results show audits were conducted for PCPs, specialists, NCQA oncology, NCQA OB/GYN, and behavioral health providers for appointment. After-hours access was conducted for PCPs and pediatrics. The report was detailed and included a corrective action plan for non-compliant providers.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Quality Improvement Plan: Update the Provider Manual to include the appointment access standard, "non-life threatening emergency within 6 hours" that is defined in Policy SC22 OP-NI-002.
3.2 The Telephonic Provider Access Study conducted by CCME shows improvement from the previous study's results.			X			The *Telephonic Provider Access Study* conducted by CCME reflects that calls were successfully answered 42% of the time (124/298) by personnel at the correct practice, which estimates between 39.11% and 44.11% for the entire population using a 95% Confidence Interval. When compared to last year's results of 46%, this year's rate of answered calls decreased. For those not answered successfully (n=174 calls), 84 (48%) were unsuccessful because the provider was not at that office or phone number listed. *Quality Improvement Plan: Regarding member's access to their providers, identify and address barriers in the update process so that having up-to-date contact information for members is not an issue. Create an action plan for ensuring provider contact information is accurate.*
II C. Provider Education						
1. The MCO formulates and acts within policies and procedures related to initial education of providers.	X					*Policy SC22 HS-PR-001, SC Provider Training and Education,* states newly contracted providers receive initial training within 30 calendar days at the provider's office or at a

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						mutually agreed upon site. Initial orientation is performed by the provider relations representatives and the training targets office staff, doctors, nurses, administrators, and front desk personnel.
2. Initial provider education includes:						
2.1 MCO health care program goals;	X					
2.2 Billing and reimbursement practices;	X					*Policy SC22 HS-PR-001, SC Provider Training and Education,* states that topics to be discussed at training include fraud, waste, and abuse; the Federal False Claims Act; HIPAA; improper payments (kickbacks); etc. The policy states that all providers are informed of their responsibility to train their staff on the various aspects of WellCare's Compliance Program.
2.3 Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by SCDHHS;	X					
2.4 Procedure for referral to a specialist;	X					
2.5 Accessibility standards, including 24/7 access;	X					
2.6 Recommended standards of care;	X					
2.7 Medical record handling, availability, retention and confidentiality;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.8 Provider and member grievance and appeal procedures;	X					
2.9 Pharmacy policies and procedures necessary for making informed prescription choices;	X					
2.10 Reassignment of a member to another PCP;	X					
2.11 Medical record documentation requirements.	X					
3. The MCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies and procedures.	X					*Policy SC22 HS-PR-001, SC Provider Training and Education,* states that ongoing training may be accomplished by a provider orientation, newsletters, email, faxes, letters, onsite training, or other means. Methods of training include group orientations, seminars, one-on-ones, webinars, phone calls, email, etc.
II D. Primary and Secondary Preventive Health Guidelines						
1. The MCO develops preventive health guidelines for the care of its members that are consistent with national standards and covered benefits and that are periodically reviewed and/or updated.	X					WellCare adopts preventive health guidelines that are designed to detect and improve the health status of members by providing preventive care to screen for a host of acute and potentially chronic illnesses. These guidelines detail interventions for prevention or early detection of disease, recommend frequency and conditions under which interventions are required, and document the scientific basis or recognized source on which the guidelines were based. Practice guidelines are reviewed at least every two years and

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						revised as necessary. *Policy SC22 HS-QI-009, SC - Provider Clinical Practice Guidelines,* and *Procedure SC22 HS-QI-009-PR-001* define the process of evaluation and adoption of practice guidelines.
2. The MCO communicates the preventive health guidelines and the expectation that they will be followed for MCO members to providers.	X					Preventive health guidelines are mentioned in the *Provider Manual* with a link to where the guidelines are posted on the website. Providers are notified of updates to practice guidelines via the quarterly provider newsletter.
3. The preventive health guidelines include, at a minimum, the following if relevant to member demographics:						
3.1 Well child care at specified intervals, including EPSDTs at State-mandated intervals;	X					
3.2 Recommended childhood immunizations;	X					
3.3 Pregnancy care;	X					
3.4 Adult screening recommendations at specified intervals;	X					
3.5 Elderly screening recommendations at specified intervals;	X					
3.6 Recommendations specific to member high-risk groups.	X					
4. The MCO assesses practitioner compliance with preventive health guidelines through direct medical record audit and/or review of utilization data.	X					*Policy SC22 HS-QI-009, SC - Provider Clinical Practice Guidelines,* states annually, certain CPGs and PHGs are identified for compliance measurement. This is done through the certified HEDIS process of claims, encounters, and chart review. If results are not found to be

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						satisfactory, actions are taken to remediate.
II E. Clinical Practice Guidelines for Disease and Chronic Illness Management						
1. The MCO develops clinical practice guidelines for disease and chronic illness management of its members that are consistent with national or professional standards and covered benefits, are periodically reviewed and/or updated and are developed in conjunction with pertinent network specialists.	X					The process of adoption, review, and approval of clinical practice guidelines is detailed in *Policy SC22 HS-QI-009, SC - Provider Clinical Practice Guidelines*, and SC22 HS-QI-009-PR-001, SC - Pro*vider Clinical Practice Guidelines Procedure*. The clinical practice guidelines are reviewed at least every two years and revised as necessary.
2. The MCO communicates the clinical practice guidelines for disease and chronic illness management and the expectation that they will be followed for MCO members to providers.	X					Clinical practice guidelines are listed on the website and mentioned in the *Provider Manual*. Providers are notified of updates to clinical practice guidelines via the quarterly provider newsletter.
3. The MCO assesses practitioner compliance with clinical practice guidelines for disease and chronic illness management through direct medical record audit and/or review of utilization data.	X					For 2016, the use of clinical practice guidelines by WellCare providers was assessed by an analysis of HEDIS® data for all provider groups consisting of PCPs. As required by *SC22 HS-QI-009-PR-001, South Carolina - Provider Clinical Practice and Preventive Health Guidelines Procedure,* assessment included compliance in two important aspects of practice guidelines for a preventive guideline, a guideline for a behavioral health condition, and a guideline for an acute or chronic medical condition.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II F. Continuity of Care						
1. The MCO monitors continuity and coordination of care between the PCPs and other providers.	X					*Policy SC22 HS-UM-019, SC - Care Coordination Continuity of Care and Transition of Care*, states that all members' health care is directed and coordinated by or through the member's PCP. WellCare's policy is to implement appropriate robust continuity of care and service efforts to ensure that members receive the appropriate care and services to which they are entitled. Processes are defined for care coordination, continuity of care, and transition of care for members. PCPs are monitored via HEDIS visits and through over and underutilization review. In 2016, WellCare conducted an analysis of continuity and coordination between medical care and behavioral health care. At a minimum, WellCare collects data annually and has mechanisms in place to analyze data and implement at least two activities that directly affect coordination of care between medical and behavioral health practitioners. Opportunities for improvement were identified through reviewing the data and analysis.
II G. Practitioner Medical Records						
1. The MCO formulates policies and procedures outlining standards for acceptable documentation in the member medical records maintained by primary care physicians.	X					WellCare conducts a review of contracted practitioner office medical records annually as defined in *Policy SC22 HS-QI-005, South Carolina - Medical Record Review*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Standards for acceptable documentation in member medical records are consistent with contract requirements.	X					
3. Medical Record Audit						
3.1 The MCO monitors compliance with medical record documentation standards through periodic medical record audit and addresses any deficiencies with the providers.		X				*Policy SC22 HS-QI-005, South Carolina - Medical Record Review,* states that WellCare conducts annual review of contracted practitioner office medical records utilizing criteria based on contractual requirements and federal and state regulations. The policy states that practitioners are provided results of the review and if the physician's overall review results are below 80%, a corrective action plan is issued and the provider is re-audited during the next cycle. WellCare conducted an annual medical record review in 2015 and results showed that 650 records (65 providers) were received out the 720 requested. A total of 57 providers passed the audit with eight providers (80 records) failing the review. The results documentation does not explain what criteria was used to determine a failed score and does not explain what follow-up took place for the providers placed on a corrective action plan. During onsite discussion, WellCare was unsure when a provider is re-audited after being placed on corrective action. Since the policy states that a provider is re-audited during the next cycle, an assumption is made the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						providers would not be re-audited until the following year's annual review. *Quality Improvement Plan: Ensure corrective action is addressed in the medical record review audit results and follow-up is conducted in a timely manner for those providers that fail the medical record review.*
4. Accessibility to member medical records by the MCO for the purposes of quality improvement, utilization management, and/or other studies is contractually assured for a period of 5 years following expiration of the contract.	X					

III. MEMBER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
III. MEMBER SERVICES						
III A. Member Rights and Responsibilities						
1. The MCO formulates and implements policies outlining member rights and responsibilities and procedures for informing members of these rights and responsibilities.	X					*Policy SC22 OP-CS-023, South Carolina - Medicaid Customer Service Disclosure of Rights and Responsibilities*, defines enrollee rights and WellCare's processes for informing

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						members of their rights and responsibilities.
2. Member rights include, but are not limited to, the right:	X					Member rights are appropriately documented in *Policy SC22 OP-CS-023, South Carolina - Medicaid Customer Service Disclosure of Rights and Responsibilities*, the *Member Handbook*, the *Provider Manual*, and on the WellCare website.
2.1 To be treated with respect and dignity;						
2.2 Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;						
2.3 To participate in decision-making regarding their health care, including the right to refuse treatment;						
2.4 To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, in accordance with Federal regulations;						
2.5 To be able to request and receive a copy of the member's medical records and request that they be amended or corrected as specified in Federal regulation;						
2.6 To freely exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCO and it providers or the Department treat the Medicaid MCO Member.						
III B. Member MCO Program Education						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. Members are informed in writing within 14 business days of enrollment of all benefits to which they are contractually entitled, including:		X				WellCare provides the *Member Handbook* no later than 14 calendar days from receipt of enrollment data from SCDHHS. A *Member Handbook* change control log is available on the WellCare website. Issues noted in the *Member Handbook* are addressed in the standards below.
1.1 Full disclosure of benefits and services included and excluded in their coverage;						
1.1.1 Benefits include direct access for female members to a women's health specialist in addition to a PCP;						
1.1.2 Benefits include access to 2nd opinions at no cost including use of an out-of-network provider if necessary.						
1.2 How members may obtain benefits, including family planning services from out-of-network providers;						
1.3 Any applicable deductibles, copayments, limits of coverage, maximum allowable benefits and claim submission procedures;						The *Member Handbook* contains a grid defining member co-payment amounts and benefit limits. Similar grids are found in the *Provider Manual* and on the WellCare website. Discrepancies in co-payment amounts and benefit limits were noted between the information in the *Member Handbook*, the website, and the *Provider Manual* for the following services: •Ambulatory Surgical Center—the *Member Handbook* lists a co-payment of $3.30, but the website and *Provider Manual* state the co-pay

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						is $0. •Chiropractic—the *Member Handbook* and *Provider Manual* state there is a limit of 6 visits per year, but the website states the limit is 8 visits per year. •DME—the *Member Handbook* lists a co-payment of $3.40, but the website and *Provider Manual* state the co-payment is $0. •Eye exams/vision services—the *Member Handbook* lists a $3.30 co-payment for members 19 and 20. The website and *Provider Manual* state the co-payment is $0 for members 19 and 20. •FQHC services—the *Member Handbook* states the co-payment is $3.30, but the website and *Provider Manual* list the co-payment as $0. •Home health services—the *Member Handbook* co-payment amount is $3.30, but the website and *Provider Manual* list the co-payment as $0. •Physician services—the *Member Handbook* co-payment amount is $3.30, but the website and *Provider Manual* state $0. •Podiatry services—the *Member Handbook* states a $1.15 co-payment, but the website and *Provider Manual* state $0. •RHC Services—the *Member Handbook* lists a co-payment of $3.30, but the website and *Provider Manual* state $0. *Quality Improvement Plan: Revise the benefit grids in the Member Handbook, Provider Manual, and website so that information on*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						benefits limits and copayment amounts is consistent.
1.4 Any requirements for prior approval of medical care including elective procedures, surgeries, and/or hospitalizations;						The following statement in the *Member Handbook* makes it appear that the PCP can approve services without seeking an authorization from WellCare, and could result in confusion for members: "Sometimes we may not have a provider in our network who can give you needed care. If this happens, we'll cover the care out-of-network (at no additional cost to you), but you will need to get approval first from us or your PCP." *Quality Improvement Plan: In the Member Handbook, revise the statement above so that it is clear that out-of-network care must be authorized by WellCare.*
1.5 Procedures for and restrictions on obtaining out-of-network medical care;						
1.6 Procedures for and restrictions on 24-hour access to care, including elective, urgent, and emergency medical services;						The *Member Handbook* informs members of the availability of the 24-hour Nurse Advice Line and instructs members to call 911 or go to the nearest emergency room in cases of emergency. The handbook defines urgent versus emergency care and how to obtain services.
1.7 Procedures for post-stabilization care services;						The *Member Handbook* defines and provides information on coverage of post-stabilization services.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.8 Policies and procedures for accessing specialty/referral care;						
1.9 Policies and procedures for obtaining prescription medications and medical equipment, including applicable copayments and formulary restrictions;						The *Member Handbook* states, "Prescriptions must be written by one of our network providers." It further states, "Your PCP must approve a prescription from an out-of-network provider." Onsite discussion confirmed prescriptions may be written by out-of-network providers and there is no requirement that the PCP must approve those prescriptions. *Quality Improvement Plan: Correct the information above in the Member Handbook.*
1.10 Policies and procedures for notifying members affected by changes in benefits, services, and/or the provider network, and providing assistance in obtaining alternate providers;						The *Member Handbook* defines requirements for and methods of member notification when WellCare chooses not to cover a benefit due to moral or religious grounds, other benefit changes, and when a provider is terminating from the network.
1.11 Procedures for selecting and changing a primary care provider and for using the PCP as the initial contact for care;						*Policy SC22 OP-CS-006, South Carolina - Change of Primary Care Physician*, defines WellCare's processes for member-requested PCP changes. The *Member Handbook* provides appropriate information for members to understand the process and requirements for PCP changes.
1.12 Procedures for disenrolling from the MCO;						The *Member Handbook* contains brief information about member-requested disenrollment, and states members may request disenrollment without cause within 90 days of enrollment. The handbook does not clearly describe for-cause disenrollment

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						requests or provide examples of reasons a member may request disenrollment for cause. Refer to the *SCDHHS Contract, Section 3.3.2.4.3.* *Quality Improvement Plan: Revise the Member Handbook to provide detailed information about for-cause disenrollment requests, including examples of reasons members may request for-cause disenrollment.*
1.13 Procedures for filing grievances and appeals, including the right to request a Fair Hearing through SCDHHS;						
1.14 Procedure for obtaining the names, qualifications, and titles of the professionals providing and/or responsible for their care and of alternate languages spoken by the provider's office;						Members are instructed via the *Member Handbook* to consult the printed provider directory, the online provider search tool, or to call Member Services to choose providers.
1.15 Instructions on how to request interpretation and translation services when needed at no cost to the member;						The provision of translation services is addressed in *Policy SC22 OP-CS-017, South Carolina - Medicaid Interpreter Services.* The *Member Handbook* informs that translation services are available at no cost and includes that in-person translation can be provided at provider appointments. Members are instructed to contact Member Services for translation requests.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.16 Member's rights and protections, as specified in 42 CFR §438.100;						Member rights and responsibilities are included in the *Member Handbook* and on the WellCare website.
1.17 Description of the purpose of the Medicaid card and the MCO's Medicaid Managed Care Member ID card and why both are necessary and how to use them;						
1.18 A description of Member Services and the toll-free number, fax number, e-mail address and mailing address to contact Member Services;						The *Member Handbook* includes the toll-free Member Services telephone and TTY number, fax number, and mailing address, and informs members that they can send an email using the "Contact Us" link on the WellCare website.
1.19 How to make, change and cancel medical appointments and the importance of canceling and/or rescheduling rather than being a "no show";						
1.20 Information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services						
1.21 A description of Advance Directives, how to formulate an advance directive and where a member can received assistance with executing an advance directive;						
1.22 The SCDHHS fraud hotline and fraud email address and toll-free line;						The *SCDHHS Contract, Section 11.2.9.1*, requires SCDHHS' fraud hotline, fraud email address, and toll-free line to be placed in a prominent position in all member

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						communications so that members may easily identify the information. This information, located on pages 65-66 of the *Member Handbook* document, is not displayed in a prominent location. *Recommendation: Ensure information on reporting fraud, waste, and abuse, appear in a prominent position in the Member Handbook.*
1.23 Additional information as required by the contract and by federal regulation.						
2. Members are informed promptly in writing of changes in benefits on an ongoing basis, including changes to the provider network.		X				*Policy SC22 HS-UM-017, South Carolina - Cont'd Care with Termed Provider and Not to Members of Specialist Term*, defines requirements and processes for member notification of PCP terminations. The policy includes the timeframe for member notification of a PCP termination, but does not specify the timeframe for notification of a specialist termination. The *SCDHHS Policy & Procedure Guide, Appendix 1*, states members have the right to receive notice of any significant changes in the benefits package at least 30 days before the intended effective date of the change. However, WellCare did not submit a policy that addresses member notification of changes to services or benefits. CCME requested the policy, but it was not provided. Onsite discussion confirmed WellCare is following

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						appropriate processes. *Recommendation: Add the timeframe for member notification of a specialist's termination from the network to Policy SC22 HS-UM-017.* *Quality Improvement Plan: Include a policy detailing the requirements and process for notifying members of changes to services and benefits.*
3. Member program education materials are written in a clear and understandable manner, including reading level and availability of alternate language translation for prevalent non-English languages as required by the contract.	X					*Policy SC22 SM-004, South Carolina - Medicaid Written Member Materials and Marketing Materials Review and Approval Process, Addendum A—South Carolina*, states WellCare ensures all member material is written at no higher than a 6th grade reading level. The method used to determine reading level of member materials was not mentioned in the policy. Onsite discussion confirmed WellCare uses the Flesch-Kincaid method to determine readability. Member materials are available in alternate formats including foreign languages, large font, audio, and Braille. *Recommendation: Include the method used to determine readability level of member materials in Policy SC22 SM-004.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. The MCO maintains and informs members of how to access a toll-free vehicle for 24-hour member access to coverage information from the MCO, including the availability of free oral translation services for all languages.	X					Member Services contact information is documented throughout the *Member Handbook* and other member materials. The Member Services call center is available from 8 a.m. to 6 p.m. Monday – Friday. Outside of normal business hours, an automated system provides callers with instructions on what to do in case of an emergency, and callers have the option to leave a message on a confidential voice mailbox. In addition, the toll-free Nurse Advice Line is available 24-hours a day. *Policy SC22 OP-CS-001, South Carolina - Medicaid Customer Service Requirements*, defines call center service level requirements which are compliant the *SCDHHS Contract, Section 3.8.3*. Quality Improvement Committee (QIC) minutes from 6/2/16 indicate WellCare's call center metrics fall within requirements.
5. Member grievances, denials, and appeals are reviewed to identify potential member misunderstanding of the MCO program, with reeducation occurring as needed.	X					
6. Materials used in marketing to potential members are consistent with the state and federal requirements applicable to enrollees and members.	X					
III C. Member Disenrollment						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. Member disenrollment is conducted in a manner consistent with contract requirements.	X					Requirements and processes for member disenrollment are addressed in *Policy SC22 OP-EN-005, South Carolina - Disenrollment*.
III D. Preventive Health and Chronic Disease Management Education						
1. The MCO enables each member to choose a PCP upon enrollment and provides assistance as needed.	X					Attempts are made to contact new members to provide telephonic orientation to WellCare and to encourage members to select a PCP if one is not already selected. Per *Policy SC22 OP-CS-006, South Carolina - Change of Primary Care Physician*, WellCare offers each member a choice of PCPs and assigns a PCP to members who did not select one at enrollment. Members may change their PCP at any time and as often as desired.
2. The MCO informs members about the preventive health and chronic disease management services that are available to them and encourages members to utilize these benefits.	X					The *Member Handbook* includes an introduction to preventive health guidelines and specifies the guidelines for adult and pediatric screenings and immunizations. Members are instructed to discuss the recommendations with their provider. Reminder notices for recommended services are sent to members in accordance with Medicaid contract requirements, the American Academy of Pediatrics (AAP) Periodicity Schedule, and the United States Preventive Services Task Force Preventive Health Recommendations.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						WellCare sends gaps in care reports to providers and the information is available on the provider portal. Customer service representatives also see gaps in care information when interacting with members and can assist with scheduling appointments for recommended services. WellCare's Healthy Behaviors member incentive program encourages timely completion of health screenings and preventive services by offering gift cards. The *Member Handbook* presents information on disease management programs for asthma, diabetes, coronary artery disease, congestive heart failure, chronic obstructive pulmonary disease, hypertension, smoking cessation, and weight management. The *Provider Manual* lists disease management programs, but does not include weight management. *Recommendation: Include weight management in the list of disease management programs in the Provider Manual.*
3. The MCO identifies pregnant members; provides educational information related to pregnancy, prepared childbirth, and parenting; and tracks the participation of pregnant members in their recommended care, including participation in the WIC program.	X					WellCare identifies pregnant members through a variety of methods, including welcome calls, health risk assessments, claims and authorization data, and notice of pregnancy forms. The *Member Handbook* includes information on

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						pregnancy and newborn care and a "To Do" list for pregnant members. The handbook informs members that WellCare can assist with making baby appointments, and provides information on the Women, Infants and Children (WIC) program and the availability of Care Management for high-risk pregnancies. WellCare provides tools and information for a healthy pregnancy including assessments and the current recommended infant immunization schedule. The *Mommy & Baby Matters* booklet provides comprehensive information on pregnancy, pregnancy prevention, infant care, safety, milestones, and preventive care recommendations.
4. The MCO tracks children eligible for recommended EPSDTs and immunizations and encourages members to utilize these benefits.	X					*Policy SC22 HS-QI-012, South Carolina - Early Periodic Screening, Diagnosis, and Treatment (EPSDT)*, defines EPSDT requirements and components of EPSDT exams. Eligible members who have not had a visit for a child health screening are identified monthly by claims and encounter data, and a letter is mailed with education on the need to see their PCP. WellCare informs members of all testing and screenings due according to the AAP periodicity schedule, and encourages members to obtain health assessment and preventative care.
5. The MCO provides educational opportunities to members regarding health risk factors and wellness promotion.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
III E. Member Satisfaction Survey						
1. The MCO conducts a formal annual assessment of member satisfaction with MCO benefits and services. Such assessment includes, but is not limited to:	X					WellCare contracts with SPH Analytics, a certified CAHPS survey vendor, to conduct the adult and child surveys. Survey response rates were 18.6% (Child) and 25% (Adult). These rates are lower than the previous year's (2015) rates of 26.4% for children and 30.8% for adults. *Recommendation: Continue working with vendors to increase response rates for the child and adult surveys. To increase response rates, suggestions include adding a reminder to call center scripts, placing a stamp on initial and follow-up mailings, increasing the sample size, and allowing a longer timeline to send additional reminders and conduct phone call surveys. CCME also recommends that WellCare decide upon and document an internal goal to increase response rates (such as a 3% increase each year).*
1.1 Statistically sound methodology, including probability sampling to insure that it is representative of the total membership;	X					
1.2 The availability and accessibility of health care practitioners and services;	X					
1.3 The quality of health care received from MCO providers;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.4 The scope of benefits and services;	X					
1.5 Claim processing procedures;	X					
1.6 Adverse decisions regarding MCO claim decisions.	X					
2. The MCO analyzes data obtained from the member satisfaction survey to identify quality problems.	X					SPH Analytics summarizes and details all results from the adult and child surveys, and WellCare analyzes the vendor reports.
3. The MCO implements significant measures to address quality problems identified through the member satisfaction survey.	X					Interventions focus on items that are below standard. The CY 2015 Evaluation document (pgs.95-99) provides evidence of analysis, discussion, and initiatives to address problematic areas of member satisfaction.
4. The MCO reports the results of the member satisfaction survey to providers.	X					The *Provider Newsletter, 2016 Issue 3*, has an overview of the 2016 CAHPS Survey Results.
5. The MCO reports to the Quality Improvement Committee on the results of the member satisfaction survey and the impact of measures taken to address those quality problems that were identified.	X					Quality Improvement Committee (QIC) documentation from 8/18/16 includes the *Medicaid Annual Member Experience Survey Evaluation*. The QIC is involved in generating interventions and initiatives that address problematic areas of member satisfaction.
III F. Grievances						
1. The MCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to:	X					*Policy SC22 OP-GR-001, South Carolina - Medicaid Grievance Policy*, defines member grievance requirements and processes. *Policy SC22 OP-CS-021, South Carolina - Medicaid Customer Service Intake of Member Grievances*, defines processes for grievance intake.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.1 Definition of a grievance and who may file a grievance;	X					
1.2 The procedure for filing and handling a grievance;	X					*Policy SC22 OP-GR-001, South Carolina - Medicaid Grievance Policy*, does not define a timeframe for filing a grievance; however, the *Member Handbook*, *Provider Manual*, and the WellCare website state the timeframe to file a grievance is within 30 days of the date of the event that caused dissatisfaction. Onsite discussion confirmed the timeframe to file a grievance will be added during the next revision of *Policy SC22 OP-CS-001*. *Recommendation: Ensure Policy SC22-OP-CS-001, is updated to include the 30-day timeframe for filing a grievance.*
1.3 Timeliness guidelines for resolution of the grievance as specified in the contract;	X					*Policy SC22 OP-GR-001, South Carolina - Medicaid Grievance Policy*, states grievance decisions are rendered and written resolution provided no more than 90 calendar days from the day the grievance is received. The 90-day timeframe is documented in the *Member Handbook*, *Provider Manual*, and on WellCare's website. Appropriate information on extensions of grievance resolution timeframes is included in *Policy SC22 OP-GR-001, South Carolina - Medicaid Grievance Policy*, the *Member Handbook*, and *Provider Manual*. The WellCare website informs members that they may

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						request an extension of the grievance resolution timeframe, but does not indicate that WellCare may initiate an extension and under what conditions. *Recommendation: Add information to the WellCare website that the plan may initiate an extension of the grievance resolution timeframe and under what circumstances this may occur. Refer to the SCDHHS Contract, Section 9.7.2.4.1.*
1.4 Review of all grievances related to the delivery of medical care by the Medical Director or a physician designee as part of the resolution process;	X					*Policy SC22 OP-GR-001, South Carolina - Medicaid Grievance Policy*, indicates WellCare ensures the decision-makers for clinical grievances are not involved in any of the previous levels of review or decision-making. For grievances regarding denial of expedited resolution of an appeal and grievances involving clinical issues, the decision-maker is a medical director or physician designee with expertise in treating the member's condition or disease.
1.5 Maintenance of a log for oral grievances and retention of this log and written records of disposition for the period specified in the contract.	X					Grievance logs are maintained for 10 years. Grievances are tracked, trended, and reported to the Customer Service Quality Improvement Workgroup (CSQIW), Medical Advisory Committee (MAC), and QIC.
2. The MCO applies the grievance policy and procedure as formulated.	X					Review of grievance files reflected thorough documentation, investigation, and resolution of member complaints. Resolutions met timeliness requirements; however two acknowledgement letters were not in compliance with the 5

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						business-day requirement for acknowledgement. Also, 2 acknowledgement letters have typographical errors in the letter's date. Onsite discussion confirmed a quality assurance process has been implemented to review each letter prior to mailing. *Recommendation: Ensure acknowledgement letters are sent within required timeframes.*
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					
4. Grievances are managed in accordance with the MCO confidentiality policies and procedures.	X					
III G. Practitioner Changes						
1. The MCO investigates all member requests for PCP change in order to determine if such change is due to dissatisfaction.	X					
2. Practitioner changes due to dissatisfaction are recorded as grievances and included in grievance tallies, categorization, analysis, and reporting to the Quality Improvement Committee.	X					
3. The timeliness guideline for completing a member's request to change their PCP is consistent with contract requirements.	X					

IV. QUALITY IMPROVEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
IV. QUALITY IMPROVEMENT						
IV A. The Quality Improvement (QI) Program						
1. The MCO formulates and implements a formal quality improvement program with clearly defined goals, structure, scope and methodology directed at improving the quality of health care delivered to members.	X					WellCare's *2016 Medicaid Quality Improvement (QI) Program Description* outlines the process in place for measuring and improving the care and services received by its members and their providers. The program description includes the program goals, objectives, structure, and scope.
2. The scope of the QI program includes monitoring of provider compliance with MCO wellness care and disease management guidelines.	X					Per the *2016 Medicaid Quality Improvement Program Description,* WellCare monitors provider compliance with national standards of care. According to policy *SC22 HS-QI-009, South Carolina - Provider Clinical Practice Guidelines and Preventive Health Guidelines,* annually certain clinical practice guidelines and preventive health guidelines are identified for compliance. WellCare's procedure, *SC22 HS-QI-009-PR-001* discusses the process the healthplan uses for monitoring provider compliance with the guidelines. Monitoring was not included in the 2015

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						program evaluation or in the 2015 and 2016 work plans. An example report with some analysis was provided. *Recommendation: Ensure the monitoring of provider compliance with clinical and preventive practice guidelines is conducted annually per WellCare's procedure, SC22 HS-QI-009-PR-001*
3. The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems.	X					
4. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframe for implementation and completion, and the person(s) responsible for the project(s).	X					
IV B. Quality Improvement Committee						
1. The MCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					The Quality Improvement Committee (QIC) has been established to provided oversight and approval of all planned activities. According to the 2016 QI program description, the committee is chaired by the senior medical director, meets at least quarterly, and a quorum is determined by at least four voting members. The Utilization Medical Advisory Committee

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						(UMAC) oversees all clinical QI and utilization management and behavioral health activities. According to the *QI Program Description*, the committee provides an avenue where network providers can offer recommendations about the health plans QI and utilization management activities.
2. The composition of the QI Committee reflects the membership required by the contract.	X					The attendance by network providers on the UMAC continues to be poor; however, two new network providers joined in May.
3. The QI Committee meets at regular quarterly intervals.	X					
4. Minutes are maintained that document proceedings of the QI Committee.	X					Minutes reviewed were well documented. CCME found errors regarding who chaired the Quality Improvement Committee. According to some minutes, the meeting was chaired by the medical director and in others the meeting was chaired by the director of quality improvement. *Recommendation: Ensure that the Quality Improvement Committee is always chaired by the medical director or a designee and that this is documented in committee minutes.*
IV C. Performance Measures						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures".	X					WellCare uses Inovalon, a certified software organization, for calculating HEDIS rates and the verifying measures are fully compliant and consistent with the CMS protocol

STANDARD	SCORE					COMMENTS
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						requirements. The comparison from 2014 to 2015 revealed a strong increase in Use of First Line Psychosocial Care for Children and Adolescent on Antipsychotics with a 48% increase for 6-11 year olds and 48% increase for 12-17 year olds. The most problematic measures were the Immunization Rates with decreases of over 10% for several measures. All immunization rates decreased. The HbA1C Poor control rate increased over 10%, and the Adult BMI Assessment rate decreased almost 10%. The complete validation results are found in *Attachment 3, EQR Validation Worksheet*. *Recommendation: Consider and find specific ways to address HEDIS rates that are not progressing positively.*
IV D. Quality Improvement Projects						
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population.	X					Two projects were validated using the CMS Protocol for Validation of Performance Improvement Projects.
2. The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects".	X					Both projects scored within the *High Confidence Range and met the validation protocol*. The complete validation results are found in *Attachment 3, EQR Validation Worksheet*.
IV E. Provider Participation in Quality Improvement Activities						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO requires its providers to actively participate in QI activities.	X					*Policy SC22 HS-QI-011, Quality Improvement Program and Provider Involvement* address this standard.
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					Results of provider monitoring and gaps in care.
IV F. Annual Evaluation of the Quality Improvement Program						
1. A written summary and assessment of the effectiveness of the QI program for the year is prepared annually.	X					WellCare provided their *2015 Medicaid Quality Improvement Program Evaluation* for review.
2. The annual report of the QI program is submitted to the QI Committee and to the MCO Board of Directors.	X					

V. UTILIZATION MANAGEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V. Utilization Management						
V A. The Utilization Management (UM) Program						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to:	X					WellCare's *2016 Utilization Management (UM) Program Description* is evaluated and updated annually and was approved by the Utilization Medical Advisory Committee (UMAC) on 5/9/2016 and the Quality Improvement Committee (QIC) on 6/2/2016. The *UM Program Description* defines the goals and processes WellCare uses to ensure access to quality health care for all members. WellCare uses standardized medical necessity criteria such as InterQual®, Hayes, and generally accepted best practices applied by licensed staff to process requests for care. Case management/field service coordinators, Disease Management, and the quality department work closely with UM.
1.1 structure of the program and methodology used to evaluate the medical necessity;	X					
1.2 lines of responsibility and accountability;	X					Utilization processes are managed by the corporate office and performed at the regional level. Lines of responsibility and accountability are defined in the UM and Quality program descriptions as well as the organizational charts submitted.
1.3 guidelines / standards to be used in making utilization management decisions;	X					All clinical coverage criteria are approved by the Utilization Management Advisory Committee (UMAC) and the Quality Improvement Committee (QIC) and are detailed in Policy SC22 HS-UM-005, Clinical Coverage Guidelines. Criteria used includes: •Interqual Criteria® •Clinical Coverage Guidelines •LOCUS and CALOCUS •ASAM •Federal and State guidelines

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•Hayes •Evidence-based guidelines Criteria can be found on the WellCare website, in the *Provider Manual*, and within the notice of action denial letters provided to members and providers.
1.4 timeliness of UM decisions, initial notification, and written (or electronic) verification;	X					Timeliness guidelines are found in the *Member Handbook*, the *Provider Manual*, WellCare's website, and the following policies: •SC22 HS-UM-023, SC Inpatient Concurrent Review •SC22 HS-UM-024, SC Continued Outpatient Services •SC22 HS-UM-025, Service Authorization Decisions *Policy SC22 HS-UM-025, Service Authorization Decisions*, states for urgent pre-service authorization decisions, WellCare will decide within 72 hours after the receipt of the request and WellCare, a member, or a provider can extend the 72 hour timeframe by 48 hours. This timeframe is also found in the *Member Handbook*. Onsite discussion confirmed WellCare expects a request for an extension of an expedited authorization that would result in a change from expedited to standard timeframe to a 14 day resolution timeframe. The policy does not include this information or inform the reader that according to *Federal Regulation § 438.210 (d) (2) (ii) and SCDHHS Contract, Section 8.7.3,* the extension for expedited authorizations is 14 days. The health plan may decide to shorten this timeframe for themselves; however the member, in accordance with the contract reference, may request an extension up 14 calendar days.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Update policy SC22 HS-UM-025 to reflect your process of changing an expedited authorization request to standard if the member requests an extension and that a member would have a possible 14 day extension if requested. Update other documents as needed to be consistent.
1.5 consideration of new technology;	X					*Policy SC22 HS-UM-011, Application of Criteria*, includes "All new medical technology or questionable experimental procedures will require review by the Medical Director prior to approval to establish guidelines where applicable."
1.6 the absence of direct financial incentives or established quotas to provider or UM staff for denials of coverage or services;	X					Present in policy, the *Member Handbook* and the *Provider Manual*.
1.7 the mechanism to provide for a preferred provider program.		X				Per the *SCDHHS Contract, Section 8.4.2.7,* the health plan is required to develop a preferred provider program based on quality resulting in the provider becoming eligible for special considerations when requesting service authorizations. WellCare has developed a program to identify high performing physicians groups using both quality and cost metrics. The goal is to reward qualifying providers financially for improving performance in these areas. There is no indication that this program offers unique authorization arrangements to providers based on improvements in quality. Onsite discussion confirmed WellCare did not document such a program because it has not identified any providers who

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						qualify for such a program. *Quality Improvement Plan: Update the High Performing Physicians Group program to include rewarding providers with special considerations when requesting service authorizations, as detailed in SCDHHS Contract, Section 8.4.2.7.*
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					WellCare has a team of physicians, nurses, and behavioral health professionals with unrestricted licenses who are appropriately trained in the principles, procedures, and standards of utilization review. Corporate medical directors complete clinical reviews for which medical necessity is not met according to UM criteria. WellCare had a behavioral health medical director position which was recently vacated and is searching for a replacement. Dr. London participates in several committees that provide oversight of UM processes including the Utilization Management Advisory Committee (UMAC), Quality Improvement Committee (QIC), Medical Policy Committee (MPC), Appeals Committee, and Credentialing Committee.
3. The UM program design is periodically reevaluated, including practitioner input on medical necessity determination guidelines and grievances and/or appeals related to medical necessity and coverage decisions.	X					WellCare evaluates and revises the UM Plan annually. The UMAC oversees all clinical QI, UM, and behavioral health activities. The UMAC is a vital avenue where network providers can offer recommendations regarding Plan practices as well as QI and UM activities. The UMAC is responsible for promoting the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						delivery of efficient and appropriate healthcare services to Plan members. The UMAC is comprised of practitioner representation from both primary care and select specialists. The UMAC utilizes additional physician input when the need arises for specialty area case review. Behavioral Health is represented on this committee.
V B. Medical Necessity Determinations						
1. Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations.	X					
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					*Policy SC22 HS-UM-011, Application of Criteria* states WellCare's policy that UM determinations rendered are fair and consistent. The policy states that medical review criteria are objective and based on sound medical evidence, and that appropriate health care professionals are involved in the development, adoption, and update of utilization medical review criteria. Approval files reviewed demonstrate that WellCare processes requests for authorization in a timely fashion and communicates the approval to the requesting physician per contract requirements. File review ended after the first 10 files were found to be 100% compliant.
3. Coverage of hysterectomies, sterilizations and abortions is consistent with state and federal regulations.	X					*Policy SC22 HS-UM-030, South Carolina-Hysterectomies, Sterilizations and Abortions*, is consistent with State and Federal requirements. The *Provider Manual* and the *Member Handbook* contain appropriate information about these services.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					The *UM Program Description* states the Utilization Management Department maintains a process for gathering pertinent clinical information; applying criteria/guidelines during the utilization review decision making process based on individual needs, age, co-morbidities, complications, progress of treatment, psychosocial situation, home environment; and when applicable, an assessment of the local delivery system. *Policy SC22 HS-UM-011, Application of Criteria*, confirms that individual circumstances as noted above are considered in UM decisions.
5. Utilization management standards/criteria are consistently applied to all members across all reviewers.	X					*Policy SC22 HS-UM-007, South Carolina-Interrater Reliability*, affirms the Health Services Training Department administers an annual examination to licensed reviewers and medical directors conducting UM or Appeals medical necessity decisions. It states the benchmark for passing is 80% and defines a process for re-training when obtaining a score of less than 80%. IRR is InterQual based. The *2016 UM Program Description*, page 12, indicates the benchmark for IRR is 85%. Onsite discussion confirmed the benchmark is 80%. The results of the 2015 testing following allowable re-takes, was a pass rate of 100%. Results were reported to the UMAC and QIC. *Recommendation: Update the UM Program Description to be consistent with Policy SC22 HS-UM-*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						007 regarding the benchmark score for IRR.
6. Pharmacy Requirements						
6.1 Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts.	X					*Policy SC22 RX-011, Medicaid Preferred Drug List* (PDL), states the Pharmacy and Therapeutics (P & T) Committee develops the Preferred Drug List (PDL) recommendations and determines drug selection per state requirements. WellCare has appropriate restrictions including step therapy, prior authorization, quantity or age limits, and generic substitutions. Over-the-counter medications are covered with a prescription. Per onsite discussion, the PDL and PDL on the website are updated quarterly. Notice is sent to providers and members in an annual newsletter of changes affecting the pharmacy program or the PDL. Updates may be communicated as needed via the website, fax blasts, or provider emails. Printed PDLs are available upon request.
6.2 If the MCO uses a closed formulary, there is a mechanism for making exceptions based on medical necessity.		X				The *Member Handbook* and *Provider Manual* include information on medication prior authorization process and the 5-day emergency supply afforded to members waiting for prior authorization. *Policy SC22 RX-003, Emergency Medication Overrides*, states members are allowed 1 emergency override per medication within a 365 day period. Onsite discussion confirmed the statement allowing only 1 emergency override annually is not accurate and should be removed from the policy.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Page 2 of *Policy SC22 RX-005, SC Pharmacy Lock-In Program,* and page 109 of the *Provider Manual* state members in the Lock-In Program will be reviewed by the P&T Committee. (The policy states at least once during the lock-in period, which is 24 months and the *Provider Manual* states annually.) Onsite discussion revealed that WellCare is not reviewing these members. No evidence of review was found in the P&T Committee minutes. *SCDHHS Contract, Section 4.7.4.1.6* states policies and procedures must include periodic evaluation of members in the lock-in program and shall occur at least annually. *Quality Improvement Plan: Update policy SC22 RX-003 by removing the limit on emergency medication overrides. Update Policy SC22 RX-005 to include the correct timeframe for lock-in member reviews and a process for ensuring WellCare conducts annual reviews.*
7. Emergency and post stabilization care are provided in a manner consistent with the contract and federal regulations.	X					*Policy SC22 HS-UM-028, Emergency and Post-stabilization Services*, the *Member Handbook*, and the *Provider Manual* address the requirements for coverage of emergency and post-stabilization care.
8. Utilization management standards/criteria are available to providers.	X					*Policy SC22 HS-UM-028, Application of Criteria,* includes the process for providing criteria to providers and members. The *Provider Manual* states members or providers may request a copy of the criteria used for a specific determination of medical necessity by contacting the Health Services'

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Utilization Management Department. The *Member Handbook* states members have a right to get a written explanation of the reasons for denial. How to request the criteria in writing is included in the denial letter template.
9. Utilization management decisions are made by appropriately trained reviewers.	X					The *UM Program Description* and multiple policies detail that only a medical director with the appropriate expertise may issue a denial. The qualification requirements for physician reviewers is found in the *2016 UM Program Description*.
10. Initial utilization decisions are made promptly after all necessary information is received.	X					
11. Denials						
11.1 A reasonable effort that is not burdensome on the member or the provider is made to obtain all pertinent information prior to making the decision to deny services.	X					The *UM Program Description* states that a medical director may confer with the member's PCP, board certified specialists, and other resources when making UM decisions. Files reflected attempts were made to obtain additional information needed for decision making.
11.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					*Policy SC22 HS-UM.026, Adverse Determinations Proposed Actions,* states any decision to deny a service authorization request or to authorize a service in an amount, durations, or scope that is less than requested, must be made by a healthcare professional who has the appropriate clinical expertise in treating the member's condition or disease. Denials based on benefit coverage, level of care, or utilization of a contracted provider will be reviewed by a licensed medical professional. A

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						currently licensed medical director will review all adverse determinations based on medical necessity. All denial files reviewed reflected 100% compliance with timeframes and notification requirements. Appropriate physician reviewers were used to make determinations.
11.3 Denial decisions are promptly communicated to the provider and member and include the basis for the denial of service and the procedure for appeal.	X					Members are notified in writing and providers are notified per fax, phone, or email, of any decisions to deny a request for services. Notices include the information required by the *SCDHHS Contract* and Federal Regulations.
V C. Appeals						
1. The MCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an action by the MCO in a manner consistent with contract requirements, including:	X					
1.1 The definitions of an action and an appeal and who may file an appeal;	X					The definition of an action, an appeal, and who may file an appeal is correct in the following documents: •*Policy SC22 HS-AP-002 Member Appeals Policy* •*Provider Manual* •*The Member Handbook*
1.2 The procedure for filing an appeal;		X				The *Member Handbook*, *Provider Manual*, and *Policy SC22 HS-AP-002, Member Appeals Policy*, include the following procedural requirements: •WellCare will provide assistance to the member; •Filing can be orally or in writing and expedited appeal requests do not require written follow-up; •An opportunity to present evidence and/or review

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the case file. That WellCare acknowledges appeal requests "within 5 business days" is found in the *Member Appeals Policy* and the *Member Handbook*. It is not found in the *Provider Manual*. The *Member Handbook*, *Provider Manual*, and the policy state an appeal must be filed within 30 days of the receipt of the notice of action or within 30 day limitation. *Policy SC22 HS-AP-002, Member Appeals Policy*, states written confirmation of all oral appeal requests must be received by WellCare within 30 calendar days or the appeal may be denied by WellCare. An oral appeal will wait in inquiry status for 30 calendar days until the written statement is received. WellCare provides a form in the acknowledgement letter for that purpose. The following documents include a statement about a requirement to submit the written statement within 10 calendar days of the oral appeal request. •The *Member Handbook* states make sure you follow your oral request with a written statement within 10 calendar days of calling your appeal. •The *Provider Manual* states an oral request must be followed by a written appeal within 10 calendar days of the oral filing. •WellCare Denial Drug Utilization Form states a phone request must be followed up in writing within 10 days to be valid.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•NOA Letter and Acknowledgement letter states you must follow an oral appeal request with a written request. Make sure to do this within 10 calendar days of your oral request. •Pharmacy Appeals acknowledgement letter states the written request must be mailed back to WellCare within 10 calendar days. Per onsite discussion, WellCare requests that oral appeal requests be followed within 10 days by the written, signed statement; however, they do not require it. They stated their process is to make more than one request for the written appeal and appeal is left open until 30 days have passed since the receipt of the NOA by the member. *SCDHHS Contract, Section 9.1.4.4.1* states written confirmation of all oral requests must be received by the contractor within the timeframe established for the resolution of the appeal. *Quality Improvement Plan: Update the Provider Manual to include that WellCare acknowledges the receipt of appeals in writing within 5 business days. Ensure that the process defined in policy aligns with wording used in other documents to request written follow-up to an oral appeal and that it does not imply that filing must be in writing within 10 calendar days.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.3 Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case;	X					*Policy SC22 HS-AP-002 Member Appeals Policy and RX-012, Pharmacy Appeals*, define WellCare's processes for addressing appeal requests. Page 3 of the policy states the Plan will ensure that individuals who make decisions on grievances or appeals are not involved in any previous level of review or decision making and health professionals with appropriate clinical expertise shall make decisions for the following, and a list of 3 items is included. Item 2 of the list states "A contractor denial that is upheld in an expedited resolution and" is an incomplete sentence and does not include wording from the Federal Regulation. According to *Federal Regulation § 438.406 (a) (3) (B)*, the sentence should read "A grievance of a denial of an expedited resolution of an appeal." *Recommendation: Update Policy SC22 HS-AP-002 by removing item 2 from the list on page 3 and replacing it with the correct language from the Federal Regulation as noted above.*
1.4 A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay;	X					The timeframe for completing an expedited appeal is stated as within 72 hours of receipt with a possible extension of 14 days, and is found in the following documents: •*Policy SC22 HS-AP-002, Member Appeals* •*The Member Handbook* •*The Provider Manual*
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.6 Written notice of the appeal resolution as required by the contract;	X					Written notices of appeal resolutions are sent via certified mail include the requirements found in the *SCDHHS Contract*.
1.7 Other requirements as specified in the contract.	X					*Continuation of benefits is defined in Policy SC22 HS-AP-002, Member Appeals*, the *Provider Manual*, and the *Member Handbook*. NOA letters include how members can request continuation of benefits.
2. The MCO applies the appeal policies and procedures as formulated.	X					The appeal files reviewed demonstrate that WellCare manages appeals in a timely fashion, reviews are conducted by appropriate physician reviewers, and notifications include the required information. 2 files contained acknowledgement letters that were not sent within 5 business days. One of those files was due to an error in transmitting the appeal to the correct department, and there is no evidence for a pattern of non-compliance in this area.
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Per policy, appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities. Results is reported to the UM Advisory and Quality Improvement Committees. Discussion of appeal data was documented in committee minutes.
4. Appeals are managed in accordance with the MCO confidentiality policies and procedures.	X					WellCare complies with HIPAA, PHI, and the confidentiality provisions of the Patient Safety Rule when processing appeals and grievances.
V. D Case Management						
1. The MCO utilizes case management techniques to insure comprehensive, coordinated care for members with complex health needs or high-risk health conditions, including populations specified in the contract.	X					The *2016 Case Management Program Description* is a corporate document that is supported by SC specific case management policies and procedures. The program description defines the purpose, goals, objectives, scope, and structure of the Case

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Management Program. Case Management involves Short-Term/Transitional and High Intensity/Complex Case Management, Disease Management, Behavioral Health, and Health Coaching. Field Care Management teams consist of registered nurses, licensed clinical social workers, social workers, community health workers, care coordinators, and member outreach coordinators. They are market-based and perform care management via telephone and face-to-face in the member's current setting. The goal of the initial call or visit is to complete a comprehensive needs assessment while evaluating the member's engagement in the environment and with social support network. A Field Care Manager may use a combination of face-to-face and telephonic outreach to provide ongoing follow-up with the member. Members that may benefit from Care Management are identified from a variety of referral sources both internal and external. Eligible members are stratified using their diagnosis, severity, cost, and utilization. The 2016 Disease Management Program Description lists diseases WellCare focuses on in the DM program and includes asthma; COPD; CHF; CAD; DM; hypertension; obesity and smoking cessation. Transitional Care staff manages immediate and short-term member needs when changing levels of care, going home from the hospital or in a crisis situation. WellCare has placed an emphasis on providing appropriate Transitional Care.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V E. Evaluation of Over/ Underutilization						
1. The MCO has mechanisms to detect and document under and over utilization of medical services as required by the contract.	X					*Policy SC22 HS-UM-006, South Carolina-Under and Over Utilization,* details tools used for monitoring the under and over utilization of health care services and include the following: •Inpatient Daily Census •COGNOS (business intelligence) data •Monthly inpatient utilization reports •Pharmacy Reports •Physician profiling •Medical Record review •Physician Risk Group Reports •Nationally recognized benchmarks and historical data. Monthly utilization summary reports include ER rates, NICU, Readmits, admits per thousand, and days per thousand, to name a few.
2. The MCO monitors and analyzes utilization data for under and over utilization.	X					*Policy SC22 HS-UM-006, South Carolina-Under and Over Utilization,* details the process used by WellCare to monitor and analyze relevant data and take action to correct any patterns of potential or actual inappropriate under or over utilization.

VI. DELEGATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V I. DELEGATION						
1. The MCO has written agreements with all contractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions.	X					WellCare has written agreements with all entities performing delegated services and agreements outline responsibilities of the delegated entity. Many of the delegations are corporate contracts that provide support to WellCare and addendums define any state specific contract requirements. WellCare has delegated the following services: •UM – Advanced Medical Review (AMR); CareCore National, LLC (aka EviCore) •UM Behavioral Health – Focus Health •Nurse Advice Line – CareNet •Pharmacy – CVS •Customer Service –Teleperformance •Crisis Line – Health Integrated, Inc. •Case Management (OB and High Risk Pregnancy) – Alere •Vision – March Vision •Credentialing – Integra Partners; Linkia, LLC; Mary Black Health Network; Preferred Care of Aiken; Provider HealthLink of South Carolina, LLC; Regional Health; GA Regents (MCG Health); Greenville Hospital System Proaxis Therapy

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The MCO conducts oversight of all delegated functions sufficient to insure that such functions are performed using those standards that would apply to the MCO if the MCO were directly performing the delegated functions.		X				The delegation oversight process is addressed in several policies and procedures. *Policy SC22 CP-AO-007, SC - Delegation Oversight, Addendum D,* incorrectly states that routine visits should be scheduled within 4 – 6 weeks when the *SCDHHS Contract, Section 6.2.2.1.2.1* states a timeframe of four weeks. Oversight monitoring includes pre-delegated assessments for new delegates, annual reviews, quarterly scorecard reporting, etc. Evidence of monitoring was received for all reported delegated entities. A few issues were identified as follows: For credentialing delegation oversight: •Integra Partners and Linkia, LLC annual delegation audits did not include credentialing file review for SC. Onsite discussion confirmed this was an oversight. •AU Health (formally GA Regents (MCG Health)) annual review audit indicated "N/A – GA licensed" for the ownership disclosure form. Onsite discussion confirmed WellCare was unaware the ownership disclosure form (1514) was required for providers not located in SC that were being credentialed under the SC Contract. •Minutes from the 4/5/16 Delegation Oversight Committee showed a pre-delegation audit completed for Roper St. Francis; however, they were not listed as a delegated entity. For delegation oversight of Utilization functions: •*Procedure SC22 CP-007, SC - Delegation Oversight,*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						states on page 6 that elements of a delegates Corrective Action Plan (CAP) should be resolved within no greater than 90 days with exceptions made under certain circumstances. Some CAPs reviewed were not completed within the timeframe specified in the procedure. Onsite discussion confirmed the CAP process is being updated to include closure of CAPs within the policy timeframe, followed by a focused review process for continuous monitoring of the CAP. •Onsite discussion confirmed that annual oversight of delegated entities is behind schedule. See *SCDHHS Contract, Section 2.1.3 for specific requirements.* *Quality Improvement Plan: Update Policy SC22 CP-AO-007 to reflect the correct standard for routine appointments; ensure files are reviewed for entities in SC that have delegated credentialing; ensure ownership disclosure forms are collected for all entities where credentialing was delegated for SC; update the list of delegated entities to reflect all delegated activities.* *Recommendation:* *Update Policy SC22 CP-007, SC - Delegation Oversight Procedure, to include any changes in the CAP process, including changes to the timeframe to resolve CAPs, if applicable. Implement a process to ensure delegation oversight occurs at least once per year as required by the contract.*

VII. STATE-MANDATED SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V I I. STATE-MANDATED SERVICES						
1. The MCO tracks provider compliance with:						
1.1 administering required immunizations;	X					*Policy SC22 HS-QI-012, South Carolina - Early Periodic Screening, Diagnosis, and Treatment (EPSDT)*, defines services provided by the EPSDT program, including appropriate immunizations. Providers receive a monthly listing of children who are not in compliance with the EPSDT recommended services. Provider compliance with appropriate immunizations is assessed via annual medical record review audits and by monitoring claims and encounter data.
1.2 performing EPSDTs/Well Care.	X					*Policy SC22 OP-CL-028, South Carolina -EPSDT Child Health Check-up Services*, and *Policy SC22 HS-QI-012, South Carolina - Early Periodic Screening, Diagnosis, and Treatment (EPSDT)*, includes all required components of EPSDT services. *Policy SC22 HS-QI-012, South Carolina - Early Periodic Screening, Diagnosis, and Treatment (EPSDT)*, defines processes used for notifying members of and encouraging participation in EPSDT services. The policy also defines how and when providers are notified of EPSDT program requirements and methods of monitoring provider compliance with the program, including medical record review and monitoring claims and encounter data.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Core benefits provided by the MCO include all those specified by the contract.	X					
3. The MCO addresses deficiencies identified in previous independent external quality reviews.	X					